Australian Government

Draft National Clinical Quality Registry Strategy

Consultation Summary Report

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Introduction

The draft National Clinical Quality Registry (CQR) Strategy (the Strategy) aims to drive continuous improvements in the quality and value of health care to achieve optimised health outcomes for all Australians.

The draft Strategy was developed by the Australian and State/Territory governments, under the auspices of the former Australian Health Ministers' Advisory Council (AHMAC), working closely with the Australian Commission on Safety and Quality in Health Care (the Commission) and guided by an Expert Advisory Group.

In 2019, the Australian Government, on behalf of the former AHMAC, undertook public consultation on the draft Strategy. This involved an online submission process and webinar. The purpose of the consultation was to ensure stakeholders had the opportunity to contribute to the Strategy's development.

This report summarises the feedback provided during the consultation process and highlights key themes that will inform further development of the Strategy. The Australian Government recognises the considerable time and effort stakeholders spent in preparing submissions and thanks them for their valuable advice and continued support.

Consultation Process

The Australian Government invited stakeholders to share their views on the draft Strategy via the Department's online Consultation Hub. The Consultation Hub included a list of questions about the draft Strategy for consideration. Eighty submissions were received in total from a wide range of stakeholders including: clinicians; registries; consumers; medical specialist and peak bodies; government and non-government organisations; private providers and insurers; and the medical device/technology industry.

The Department also hosted a live webinar, which included a panel of representatives from the Department, the Commission and the Australian Institute of Health and Welfare. The panel discussed the details of the draft Strategy and took part in a live question and answer session. Around 140 stakeholders participated in the webinar and the panel answered more than 70 questions.

Summary of Common Themes

The consultations covered a wide range of ideas, issues and challenges. However, several common themes stood out in both the submissions and the webinar. These themes were raised repeatedly by stakeholders and are discussed in multiple sections of this report.

Stakeholders consistently highlighted:

- The need for national streamlining and standardisation of processes, especially for ethics, site governance, data access and linkage approvals;
- The need for more practical guidance and resources to support implementation of the national standards and best practice principles outlined in the *Commission's Framework for Australian Clinical Quality Registries* (the Framework)[1];
- The importance of on-going stakeholder involvement and clinician leadership in the development and co-design of national standards; and
- The importance of adequate and sustainable funding, including for Strategy-related activities.

[1] ACSQHC (2014) *Framework for Australian clinical quality registries*

Feedback on the draft Strategy

The consultations painted a positive picture overall, with stakeholders showing considerable support for the Strategy, its vision, and focus on optimising patient-centred care and outcomes.

For example, stakeholders stated:

> the Strategy is an '… *appropriately ambitious initiative driven by vision that is critical enabler of the current transformation in health care*…'
>
> *we commend the…development of a draft ten-year strategy, and its vision for driving patient-centred improvements in the quality and value of health care and patient outcomes, and commitment to consultation with the sector.'*

Aboriginal and Torres Strait Islander health outcomes

Stakeholders thought the draft Strategy would benefit from a stronger emphasis on improving health outcomes for Aboriginal and Torres Strait Islander peoples. The importance of a co-designed approach was emphasised, particularly in the areas of Strategy and data governance, and in ethical considerations in the collection, storage and use of data. The draft Strategy should also include how Aboriginal and Torres Strait Islander organisations can work together with governments and service providers to produce culturally appropriate measures.

Purpose and scope

Stakeholders sought further clarification about the draft Strategy's scope. Some stakeholders requested inclusion of primary care and team based care outside hospital settings, particularly in relation to chronic conditions. Others sought clarification on whether national, government funded CQRs are the only types of activities within scope.

Stakeholders also expressed the view that the Strategy should place more emphasis on the need for CQRs to be:

- 'positioned in the broader health context', including via data linkage with health and non-health data sets, and interoperability/integration with Australia's health information systems and infrastructure; and
- considered 'core business in Australia's health care system' and 'integral to a continuously, self-improving health system'.

The submissions also recognised that while CQRs serve multiple purposes, their primary purpose is to support improvement in safety and quality in clinical care and patient outcomes through the provision of risk adjusted feedback to clinicians, hospitals and other stakeholders. Stakeholders suggested this be should be more strongly reflected in the Strategy document.

Roles and responsibilities

The roles and responsibilities of strategic and implementation partners, such as State and Territory governments, should be more clearly recognised. Additional stakeholder groups, such as medical indemnity insurers and the Therapeutic Goods Administration were also suggested for inclusion as key stakeholders in the 'Roles and Responsibilities' table in the draft Strategy.

Strategic Objectives

The draft Strategy proposed four strategic objectives to guide action over the 10-year Strategy: 1) National CQRs are based on clinician/patient partnerships; 2) National CQRs are quality assured, efficient and cost effective; 3) The potential value of national CQR data is maximised; and 4) National, prioritised CQRs are sustainably funded.

Stakeholders were generally supportive of these draft objectives and thought they appropriately reflected the Strategy's purpose and vision. Detailed feedback for each objective is discussed in the following sections.

Objective 1: National CQRs are based on clinician/patient partnerships

The first draft Strategic Objective focused on ensuring operations and data outputs are clinician-led, patient-centred and deliver outcomes that matter most to patients.

Clinician/patient partnerships

The draft Strategy discussed the importance of clinician-patient partnerships in delivering patient-centred care. While most stakeholders were supportive of this, they also suggested Objective 1 include partnerships with all relevant stakeholders, such as health service teams and organisations, researchers and professional bodies.

Feedback highlighted the need for effective mechanisms to encourage participation by all stakeholders in CQRs. These should cover elements such as:

- demonstrating the value proposition for each stakeholder group (it was suggested that this be added to the draft Strategy);
- improving awareness and understanding of how data is used, collected, analysed and stored, and how the privacy and security of the data is protected; and
- explaining how guidelines, policies and legislative frameworks (either existing or to be developed) will govern data security, sharing and reporting arrangements, including in relation to qualified privilege[2] (this is discussed in more detail at **Objective 3**).

The importance of involving patients and consumers across all aspects of CQR development and operation was widely emphasised, especially in governance and reporting, development of minimum datasets, and patient reported measures.

However, concerns were raised about the level of health and data literacy required for patients/consumers to understand and interact with the information. A range of practical activities were put forward to address this, including:

- development of easy-to-use patient collection methods, including direct data input via smartphone apps;
- publishing patient friendly reports, dashboards and decision tools about various treatments and outcomes; and
- Developing tools that support shared decision making, where patients discuss information together with their clinician, to avoid misinterpretation.

The importance of tailoring information for different audiences is discussed in the 'Interactive CQRs' section below and under **Objectives 2 and 3**.

Clinician leadership

The submissions strongly emphasised the importance of maintaining clinician leadership in determining what should be collected and reported. This is critical in ensuring the data collected is accurate, meaningful and supports clinical practice change.

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[2] Qualified privilege legislation protects identifiable information from disclosure or use in court or other proceedings, where the information has been generated purely for the purpose of an approved quality improvement process.

Ongoing engagement with specialist medical colleges/societies and clinical expert groups was seen as critical for obtaining clinical leadership, advice and support. Suggested ways to encourage clinician and college involvement included:

- engaging with key specialist medical colleges and societies and key clinical expert groups (e.g. state/territory wide clinical networks/collaboratives) for clinical leadership, advice and support;
- linking CQR participation with specialist medical college professional development and accreditation requirements where appropriate;
- reducing the burden of data collection (e.g. by minimising the amount of data required and using standardised, electric data capture methods - discussed in more detail under **Objective 2**);
- timely provision of meaningful and accurate feedback to clinicians that is based on validated clinical and patient reported data, and has undergone accurate analysis, risk adjustment, benchmarking and outlier identification; and
- provision of best practice examples, education and guidance resources on optimal communication with patients to support shared decision-making.

Patient reported measures

The submissions acknowledged the important role that patient reported outcome measures (PROMs) and patient reported experience measures (PREMs) play in contributing to patient centred care. However, more consideration of how to best tailor their use for particular clinical domains and patient cohorts, and practically use and apply the data across different health settings, is needed.

The importance of standardised PROM and PREM collection was emphasised. Most stakeholders wanted a nationally standardised framework and associated resources to help them develop, analyse and report PROMs/PREMs. Ideally, a systematic collection system that is tailored to the needs of people of different ages, cultural, linguistic and socioeconomic backgrounds and computer literacy would be developed. This would need to be easily accessed and navigated, mimic platforms already used by patients/consumers, and include user-friendly tools and IT support.

The submissions encouraged the use of existing validated tools where possible, such as the International Consortium for Health Outcomes Measurement Standard Sets. These tools could then be adapted for various Australian health care settings and made fit for purpose for particular clinical specialities or jurisdictions. It was noted that PROM and PREM development activities should align with the work already underway at the national level by the Commission, and New South Wales and Victoria's state-based initiatives. Ideally, they should be co-designed with patients, clinicians and jurisdictional leads, and involve extensive user testing. The need to capture the views and experiences of Aboriginal and Torres Strait Islander peoples in a culturally appropriate way was also highlighted.

Finally, some concerns were raised about the significant cost and resources required to collect PROMs and PREMs, and the level of patient burden that can result from very long and detailed questionnaires. The submissions noted that additional support and funding was required to support this work over the long-term.

It was suggested that funding pilots could be an effective short-term activity to help build the evidence base on issues/solutions with PROMs and PREMS collection, and to showcase their benefits for clinicians, patients and other stakeholders.

‘Interactive’ CQRs

The draft Strategy discussed the use of ‘interactive CQRs’ and their potential benefits for patients. Interactive CQRs are a mechanism for patients to contribute and receive real time data on their care and outcomes, track their progress over time, and to view the data with their clinician to inform shared decision-making.

While stakeholders were generally supportive of the concept of interactive CQRs, they thought clinician and patient/consumer consultation and international best practice should inform their purpose, development and operation. This would help ensure interactive CQRs are user friendly for patients and provide meaningful information, as well as properly addressing ethical, security and privacy requirements.

Standardised guidance, education and training would be required for clinicians and patients, as would adequate funding for specialised IT infrastructure, software systems (including data visualisation), and data management.

Objective 2: National CQRs are quality assured, efficient and cost effective

The second draft Strategic Objective focused on ensuring CQRs deliver accurate, timely and sustainable outputs to help optimise patient care and outcomes.

National accreditation

The draft Strategy included several examples of successful international CQR accreditation schemes. Stakeholders were asked to consider what actions should be taken to develop national standards and an associated accreditation scheme in Australia.

Stakeholders were supportive of having national standards generally, but wanted more information on how a possible accreditation scheme would work and what it is trying to achieve. The importance of stakeholder co-design in the development of a national standard and potential accreditation scheme was strongly emphasised.

Several options for a type of scheme were discussed. These included low cost, less rigorous options, such as self-review against the national standard, through to high cost, highly rigorous options, such as external accreditation. It was suggested that each option be based on a maturity framework that has different levels of accreditation for CQRs at different stages of maturity. This could also be underpinned by legislation that recognises accredited CQRs as quality assurance activities (see **Objective 3**). Nevertheless, the overall preference in the submissions was for a scheme with a low compliance burden, accompanied by support and funding to help CQRs undertake accreditation activities.

Stakeholders were also keen for more details about how a potential accreditation scheme would link with funding. Several ideas were put forward, including:

- The development of transparent government funding guidelines that are based on agreed standards and possibly tied to accreditation scheme requirements;
- Initially funding demonstration or pilot accreditation projects with mature CQRs (i.e. those that meet most of the agreed standards already), to help identify the costs/benefits of a potential accreditation scheme; and
- Including a peer review of performance against accreditation and/or national standards as a mandatory part of funding and contract renewal (funding is discussed in more detail under **Objective 4**).

Ethics and site governance

Onerous ethics and site governance processes are one of the most common challenges currently faced by the sector. Most notably:

- Approval to collect the data is required from every participating site, which may equate to hundreds or potentially thousands of sites, especially at the national level;
- Governance and ethics requirements often differ across sites, and can include approval by multiple departments *within* each site, including lengthy negotiation with site legal teams; and
- Ethics and governance processes are typically designed for research purposes, not for on-going population-level quality improvement purposes.

Stakeholders noted that the costs and delays associated with these processes had contributed to a reduction in clinician and site participation, and in providing timely data.

Development of standardised and simplified processes were seen as the best way to begin streamlining. These national arrangements could be informed by expert review and stakeholder consultation, and include a review and harmonisation of the legal and ethical requirements across the Commonwealth and jurisdictions.

Some stakeholders suggested establishing a CQR national ethics approval body, which has oversight of a national platform for submitting ethics and site governance applications. Others advocated for a shared arrangement where, for example, the Australian and State and Territory Governments jointly develop a national ethics approval process that enacts consistent governance and legislative requirements. Advice should be sought from the CQR sector on how to best help minimise duplication, and establish best practice, in the meantime.

The need for accompanying support and guidance materials, and embedding ethics/privacy requirements into the CQR Standard and potential accreditation scheme, would be necessary regardless. This would enable patients/consumers, clinicians, CQRs, other Human Research Ethics Committees (HRECs) and researchers to better navigate the system and understand issues like opt-out consent and why it is necessary for national data collection. It was noted that this information would need to be tailored to different stakeholder groups, including for people of culturally and linguistically diverse backgrounds (reflecting the health literacy issues discussed under **Objective 1**).

Finally, it was recognised that legislated recognition of CQRs (in particular, nationally accredited CQRs) as national health system quality assurance and improvement activities would provide the authority for CQRs to collect and report data outside of the current research and ethics framework. Under such an arrangement, HREC approval would not be required, except in relation to research/clinical trial activities (though noting that some CQRs may still choose to seek ethics approval for activities conducted outside of the research framework).

Data collection

The draft Strategy highlighted data collection as another big challenge experienced by the sector.

Site capacity

Improving site capacity was one important element raised. For example, many submissions noted how the burden of data collection could affect participation. The need to balance data collection requirements with provision of patient care was highlighted, with some stakeholders noting that staff in public hospitals are already stretched.

Consequently, stakeholders thought more investment in hospital infrastructure and staffing was required to embed data collection as part of routine clinical care. This could include:

- engaging site level data stewards or data champions to help facilitate quality data collection;
- Increasing the use of standardised electronic data capture tools;
- employing dedicated data collectors to work at particular hospitals, or using a centralised pool of collectors who work across multiple sites; and
- acquiring a core dataset from private consulting rooms, to ensure private sector data is adequately represented.

Minimum datasets

Many submissions noted that the requirement for CQRs to collect a minimum data set, that is, a dataset that only includes the essential information required (including for benchmarking and risk adjustment), would help ease collection burden. This could be complemented with data linkage or imputation activities to help fill information gaps and further reduce the need for direct collect (the benefits of data linkage is discussed in more detail under **Objective 3**). Mandatory data provision could then be considered once a minimum data set has been agreed.

Systematic collection

The submissions emphasised the critical need for systematic data collection to ensure provision of high quality and timely data. Systematic data collection means that information is consistently collected in the same way, at the same time and using the same definitions. This includes defining and using standardised questions, data items and terms, both in data collection and coding; as well as using standardised data collection methodologies.

Stakeholders thought further investment in digitisation of CQRs, including facilitation of electronic data collection and consent processes, would greatly assist the systematic collection of both clinical and patient-derived data. Electronic collection would reduce data entry duplication through sourcing data either via direct entry (e.g. via tablets or mobile phones) or from existing data sources, such as administrative health data sets and health records/electronic medical records (EMRs), where available. It would also reduce inconsistencies and incompleteness resulting from manually transcribing and coding free text.

Stakeholders also supported a national approach for embedding CQR data items in EMRs, and potentially My Health Record in future. However, it was noted that a practical response to the current manual data collection issues was still required in the meantime, given widespread integration and interoperability is still several years away due to current variation in systems, technologies and capabilities across hospitals, CQRs and jurisdictions (integration and interoperability is also discussed under **Objective 3**).

Data governance

Data governance was discussed at length in the submissions. Data governance ensures that data meets agreed quality and management standards and is used and accessed with the right approvals and authority.

Privacy forms a central component of data governance. However, stakeholders said they found current privacy requirements difficult to navigate, especially when data is sourced from multiple sites, jurisdictions and the Commonwealth. To help streamline these barriers, stakeholders suggested:

- a review of privacy legislation and existing data protocols;
- harmonisation of relevant Commonwealth and State/Territory government legislation and privacy impact assessments where possible;

- review of community attitudes to data sharing and the use of personal data for safety and quality improvement purposes (the submissions suggested that the public may be more accepting than we realise); and
- development of protocols that balance privacy requirements of patients with the public good.

The submissions also emphasised the need to develop national data governance arrangements (and a legislative framework, as required) to guide and standardise data-related activities. This could cover issues such as patient consent, privacy and use of patient identifiers (reflecting the above ideas), as well as data security, collection, ownership and custodianship; quality control and oversight; sharing and access; analysis and reporting; and data linkage, interoperability and integration. Supporting data sovereignty for Aboriginal and Torres Strait Islander organisations must also be considered. It was suggested that the Commission's *Data Governance Framework* could be a good starting point.

While additional support and funding would be required to comply with these processes initially, streamlining would eventually free up more resources that could then be redirected to other activities.

Communication and collaboration

The draft Strategy discussed the idea of developing a national communication and collaboration hub that would support stakeholders to work together and learn from each other. Stakeholders were supportive of this idea, but similar to the feedback received on the accreditation scheme, were keen to know more about the purpose of the hub and how it would work.

They suggested building on existing networks and communities of practice first, such as those in Monash University and the South Australian Health and Medical Research Institute. A range of additional activities could also be considered, including an annual national colloquium; development of a CQR-specific journal; strategic use of online platforms and social media; and exploring options for direct communication pathways to hospitals.

Objective 3: The potential value of national CQR data is maximised

Objective 3 focuses on increasing data linkage, interoperability and integration. It also encourages more transparency and accountability through appropriate national reporting.

Access to tailored data and information

The draft Strategy discussed the potential to expand access to tailored CQR information for broader range of stakeholders. Stakeholders generally supported this idea and recognised the significant benefits broader access could deliver. Concerns were raised about some difficulties in accessing timely data from CQRs, mainly due to data collection or coding delays, lack of available data and information generally (other than via annual reports) and differing access policies and procedures.

Standardised national access policies, with accompanying user-friendly resources, would be beneficial. It was suggested that commitment to appropriate data sharing and access be made a condition of funding or accreditation, and that the merits of a national, centralised repository or 'data lake' of data be considered. The potential need for supporting legislation was also raised, especially for accessing both public and private hospital data.

Importantly, stakeholders sought more support and guidance for fundamental activities, such as accurate risk adjustment, outlier identification, analysis and reporting. These activities are the building blocks of an effective feedback loop – the essential component of a CQR (and one that maximises its return on investment).

It was noted that close consultation with clinicians and peak bodies was needed when designing and implementing reporting activities, and in helping to resolve issues such as accurate data supply, attribution of causation and understanding fluctuating outlier trends.

Some stakeholders had concerns about equitable access to tailored information. They noted the need for free or low cost provision of data and reports from CQRs where possible (noting this service would need to be adequately funded), and on-going collaboration with diverse groups and organisations. For example, working closely with Aboriginal and Torres Strait Islander health bodies would ensure reporting is culturally appropriate and that Aboriginal and Torres Strait Islander people are supported to manage, protect and control their own data.

Public reporting

Stakeholders recognised the potential for health system improvements through public reporting of outcomes information. They noted that public reporting encompasses a range of activities, including detailed annual reports, aggregated national reporting, tailored reporting for jurisdictions and other stakeholders, and patient centred, interactive information (as discussed above and under **Objective 2**). Publication of more aggregated outcomes data on national reporting platforms, such as the Australian Health Performance Framework, should be prioritised.

While some stakeholders noted the value of public reporting at the individual hospital or clinician level, as demonstrated by some successful examples overseas, many emphasised the need to progress this slowly and carefully in Australia given the potential for unintended consequences. These may include reduced clinician participation (given most CQRs rely on voluntary participation); avoidance of high-risk, complex patients or procedures; misrepresentation of results in the media/social media; and adverse legal and employment consequences.

In cases where reporting at the individual hospital, or potentially clinician level, is warranted, stakeholders suggested a staged approach where, for example, de-identified shadow reporting is used first, or where reporting is limited to medical specialist college/societies and state and territory governments before being assessed for suitability for a wider audience. Others thought that the protection of a Qualified Privilege scheme is required for clinicians to continue to participate in CQRs, particularly those associated with high-risk medical devices, without fear of unwarranted third party access.

Consultation and engagement with all relevant stakeholders, particularly with clinicians and peak bodies, is essential, as is learning from best practice examples, such as the Australian and New Zealand Hip Fracture Registry who already publically report hospital-level information. Patients and consumers were also recognised as a key audience for public reporting, and that tailoring information for their needs was required (as discussed in **Objective 1**).

Data linkage

The draft Strategy discussed how linking clinical and outcomes data with administrative data and other datasets is an efficient and cost effective way of supplementing the information directly collected in minimum datasets.

Stakeholders were very supportive of data linkage activities and noted the various examples already underway in the jurisdictions and research sectors. However, they noted that current data linkage approval processes are often inconsistent and difficult to navigate, which makes them time consuming and expensive. The need for approval by multiple ethics committees and data custodians, who often operate under different policy and legislative requirements, is a particular barrier.

Stakeholders also recommended that national data linkage agreements be developed. Clear technical and operational support on data linkage, best practice examples and international learnings is required, as is communication on the benefits of data sharing and data linking more broadly (similar to that outlined under **Objective 1**). Finally, the submissions suggested the Strategy address legislative and other restrictions relating to the use of individual patient identifiers to help facilitate streamlined data linkage.

Interoperability and integration

In the longer term, the Strategy envisages extensive interoperability and integration of CQR data with state-based EMRs and potentially My Health Record in future. New South Wales, for example, have already invested in 'virtual registries' that combine their EMRs with multiple clinical, patient and administrative datasets.

While stakeholders recognised the considerable benefits and savings associated with integration and interoperability, they noted many challenges that needed to be overcome first. These include:

- the diverse proprietary of information systems across Australia's healthcare sectors;
- the lack of technical capability to easily share information; and
- the large amount of unstructured, un-coded and incomplete data contained in My Health Record and other health systems.

As a result, many stakeholders thought this work needed to be phased over the life of the 10-year Strategy and beyond, as digital capabilities develop and challenges are addressed. The need to provide incentives for health service providers to engage in interoperability and integration, and private industry to build solutions was also highlighted, with stakeholders noting that current governance and service delivery models and government procurement policies do not facilitate or reward data portability.

Nevertheless, stakeholders considered that where technology and tools required for interoperability and integration are already available, they should be invested in now. Interoperability with Apple and Android devices and platforms to collect PROMs and PREMs was one example given, as was embedding agreed clinical and outcomes data items into developing EMRs as they are rolled out across Australia.

Objective 4: National CQRs are sustainably funded

The final draft Strategic Objective focused on sustainable funding. As highlighted throughout this report, adequate and ongoing funding is critical for CQRs to reach their full potential. Most stakeholders agreed that a national funding model should be developed by the Australian and State/Territory governments in partnership with other beneficiaries (such as industry, insurers, foundations and peak bodies) and in consultation with the sector.

Funding criteria

The general preference in the submissions was that Strategy-related activities and all aspects of establishment and operation of new and existing CQRs be included in scope for funding. A broader range of CQRs and collections, not just national, prioritised CQRs, could be considered as well, to help achieve broader implementation of the Strategy. This could be informed by a maturity framework, similar to that currently used in Victoria.

Stakeholders agreed that funding criteria should be transparent and linked to the national Standard and potentially an accreditation scheme. While many agreed funding should be contingent on return on investment and improvements in outcomes, it should not include financial penalties for poor performance. Domain-specific factors, such as complexity, size of the in-scope population, reporting requirements and maturity/development stage should also be considered.

The submissions discussed potential ways for how a funding model could be implemented. Some suggested a joint government committee or investment oversight committee, including major funders and jurisdictions, make the funding decisions. Others thought funding could be allocated via a competitive tender process using the agreed national criteria as mentioned above, and managed under a single health service agreement. Either way, stakeholders requested development of standardised processes, guidelines and resources for preparing funding proposals.

Prioritisation

Some stakeholders thought the criteria outlined in the Commission's *Prioritisation for clinical domains for CQR development* should continue to be used as the basis for funding prioritisation[3]. Others suggested a review of those criteria, which could consider:

- broadening the criteria to include national and State/Territory government priorities, primary care, comorbidities, high-risk therapeutics and devices and a public interest test;
- addressing gaps in quality/knowledge in clinical streams with significant potential to improve health outcomes and where economic return on investment is demonstrated;
- capitalising on existing registry/audit infrastructure to rationalise multiple registries within the same domain, to avoid duplication and ensure funding efficiencies;
- developing a process for potential disinvestment in existing CQRs to recover funding for new priority areas; and
- ensuring ongoing review of these priorities and identification of emerging priorities.

Partnership models

The general view was that governments should fund prioritised national CQRs and Strategy activities, at least initially, as this would demonstrate commitment and provide reassurance for other potential funders and certainty for CQRs. There were different views on how this could operate in practice, with some stakeholders suggesting that the Australian Government be the sole or majority funder for new national CQRs (with this contribution decreasing over time as new funders comes on board), while others thought the cost should be shared with State/Territory governments and other beneficiaries up front.

Either way, stakeholders agreed that options for non-government funding from other beneficiaries (for example, private health and medical indemnity insurers) should be explored and encouraged. Likewise, cost recovery models involving the medical device/pharmaceutical industries should be implemented where appropriate, possibly via a levy arrangement.

In cases where there are multiple funders and beneficiaries, stakeholders thought the Commonwealth should broker national funding arrangements with the different stakeholder groups. This would help ensure the right balance is found between maintaining best practice in data collection, benchmarking and outlier management and meeting requirements of the funders. Appropriate funding arrangements for CQRs operating at both the state and national level (for example, state and national cardiac registries) should also be considered.

Monitoring and Evaluation

The submissions highlighted the importance of CQRs being accountable for their expenditure and performance. CQRs should be expected to demonstrate how they are supporting improvement in clinical and patient outcomes in an annual impact statement or report, and have their activities regularly and independently reviewed before further funding is allocated. Stakeholders suggested that a national evaluation framework be developed to help guide this work.

Next steps

The feedback in this report will be used to inform further development of the Strategy in consultation with the Strategy's Expert Advisory Group. The Department will then work with the State and Territory representatives on the Strategy's Working Group to finalise the Strategy for endorsement.

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[3] ACSQHC (2016) *Prioritisation of clinical domains for CQR development*.