The value of clinical quality registries is clear, where we are going from here:
An update on the Commission’s work

Registry Special Interest Group Meeting
March 2017

Dr Robert Herkes
Clinical Director
3 March 2017

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Edge notched cards

- Historical method of indexing and sorting data
- Used by practitioners and institutions to analyse patient data and outcome
- We moved past these days
- Similarly data will provide new tools for patients, practitioners and health systems
Australian Government agency, jointly funded by all governments
Leads & coordinates national improvements in safety & quality of health care based on best available evidence
Aims to ensure that the health system is better informed, supported & organised to deliver safe & high quality care
Works in partnership with patients, consumers, clinicians, managers, policy makers & health care organisation
Aims to achieve a sustainable, safe & high-quality health system
Patient safety and quality

- Australia’s health system generally performs well compared to other OECD countries
- A significant proportion of Australian hospital admissions are associated with an adverse event
- Reduction in the rate of adverse events and unwarranted variation – could potentially produce productivity savings, as well as direct benefits to patients
- The economic benefits of improving patient safety and value are compelling
- National data systems are not sufficient on their own to support improvements

Vital Signs (2015); Health Policy Analysis (2013)

Measurement is foundational to advancing healthcare improvement

A robust safety and quality monitoring system requires multiple measurements of patient safety
Clinical quality registries

- Clinical quality registries (CQR) are a sub-set registries
- All registries have inherent value, they serve different purposes
- CQRs systematically monitor the quality (appropriateness and effectiveness) of health care, within specific clinical domains, by routinely collecting, analysing and reporting health-related information.
- The information is used to identify benchmarks, significant outcome variance, and inform improvements in healthcare quality.

<table>
<thead>
<tr>
<th>Registry type</th>
<th>Purpose</th>
<th>Info collected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Epidemiologic</td>
<td>Measure incidence of conditions, e.g., for policy planning, surveillance etc.</td>
<td>Body patient identifiers, Disease burden/variety</td>
</tr>
<tr>
<td>Post-marketing</td>
<td>Track usage of medical products, e.g., Adverse event reporting for medications, Patient care improvement</td>
<td>Patient identifiers for follow-up, Adverse events</td>
</tr>
<tr>
<td>surveillance</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Clinical quality registries

- Mechanism for feedback to clinicians, government and funders
  - longitudinal health outcome data
  - entire population
  - risk-adjustment outcomes
  - ability to compare different clinical groups
Clinical quality registries

Data → Information → Knowledge → Wisdom

- Pure and simple facts
- Structured data
- Ability to use information strategically to achieve objectives
- Capacity to choose objectives consistent with values

CQRs routinely collect health-related data in a timely, secure and reliable manner
CQRs analyse data and report health-related information to stakeholders
Information can identify benchmarks and significant outcome variance
The appropriateness and effectiveness of healthcare can be monitored

Australian Clinical Quality Registries

- Many state based registries, particularly in Victoria
- Increasing focus on national clinical quality registries, including:
  - ANZICS CORE registries
  - Australian and New Zealand Hip Fracture Registry (ANZHFR)
  - Australian and New Zealand Dialysis and Transplant Registry (ANZDATA)
  - The Australasian Cardiac Outcomes Registry (ACORE)
  - Australian Trauma Registry (ATR)
  - Australian Breast Device Registry (ABDR)
  - Prostate Cancer Outcomes Registry - Australia and New Zealand (PCOR-ANZ)
  - Australian Stroke Clinical Registry (AuSCR)
  - Australian and New Zealand Dialysis and Transplantation Registry
  - Burns Registry of Australia and New Zealand (BRANZ)
  - Australian and New Zealand Society of Cardiac and Thoracic Surgeons (ANZSCTS)
  - and more
# National Clinical Quality Registries

## Benefits
- Bigger dataset
- Increased learning opportunities
- Increased ability to identify outliers
- Efficiencies in organisational cost
- Support for smaller states, clinical units

## Challenges
- Ethics
- Differences in practices and policies
- Ongoing funding

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### Variation in Outcomes

Improvements in practice can be best achieved by identifying variation in outcomes. The funnel plots in Figure 17 show the SMRs for four different common diagnostic groups admitted to all submitting ICUs over the most recent 5 year period. For each of these groups the majority of the sites are within the funnels indicating that the variation of practice is within an acceptable range.

**Figure 17: Mean SMR for various diagnostic groups – 5yr trend**

![Chronic obstructive pulmonary group](source.png)

**Source:** APD

![Stroke group](source.png)

**Source:** APD

![Infectious diseases group](source.png)

**Source:** APD

![Gastro-intestinal malignancy group](source.png)

**Source:** APD
Framework for Australian clinical quality registries

Developed in 2014.

- Specifies national arrangements under which peak clinical groups and healthcare organisation can partner with governments to systematically monitor and report on healthcare quality
- Provides assurance that data systems, have satisfied minimum security, technical and operating standards

Commission work program

- To develop a view on the national policy context for CQRs (the framework is the overarching guide)
  - Economic evaluation of CQRs
  - Economic evaluation of clinical trail networks
  - Develop a prioritised list of clinical domains
  - Update the framework to clarify governance arrangements
  - Pilot the update framework
  - Develop a standard for CQR using the framework as the basis
CQR: Economic evaluation

- Conservatively evaluated the economic impact of five clinical quality registries in Australia
- Findings:
  - Significant net positive returns on investments and positive benefit to cost ratio
  - Substantial benefits, reflecting improvements to clinical practice and outcomes over time
  - Significant value for money, **when correctly implemented and sufficiently mature**
Selected CQRs

<table>
<thead>
<tr>
<th>Registry</th>
<th>Hosted by</th>
<th>Evidence of impact</th>
</tr>
</thead>
</table>
| Victorian Prostate Cancer Registry (Victorian PCR)                     | Monash University              | - Evaluated the effectiveness of the International Active Surveillance (IAS) guidelines.  
|                                                                        |                                | - Increased patient and provider satisfaction.                                     |
|                                                                        |                                | - Improved outcomes and survival outcomes.                                         |
|                                                                        |                                | - Reduced hospitalisations and associated costs.                                    |
| Victorian State Trauma Registry (VSTR)                                 | Monash University              | - Reduced in-hospital mortality.                                                    |
|                                                                        |                                | - Reduced average length of stay.                                                   |
|                                                                        |                                | - Better longer-term functional outcomes.                                           |
| Australia and New Zealand Intensive Care Adult Patient Database        | ANZICS                         | - Reduced length of stay, mortality, and readmission rates.                        |
| (ANZICS APD)                                                           |                                | - Better functional outcomes.                                                       |
| Australia and New Zealand Dialysis and Transplantation Database        | Royal Adelaide Hospital        | - Reduced graft failure rates over time.                                            |
| (ANZDATA)                                                              |                                | - Reduced mortality.                                                                |
| Australian Orthopaedic Association National Joint Replacement Registry | University of Adelaide         | - Reduced re-admission rates.                                                       |
| (AOANJRR)                                                              |                                | - Improved clinical outcomes.                                                       |

CQR: Economic evaluation results

<table>
<thead>
<tr>
<th>Registry</th>
<th>Period of analysis</th>
<th>National coverage</th>
<th>Benefit</th>
<th>Cost</th>
<th>BCR</th>
<th>Extrapolated Benefit</th>
<th>Extrapolated Cost</th>
<th>Extrapolated BCR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Victorian PCR</td>
<td>2009/10</td>
<td>11%</td>
<td>$6.5m</td>
<td>$2.7m</td>
<td>2.5</td>
<td>$44m</td>
<td>$8.9m</td>
<td>5.0</td>
</tr>
<tr>
<td>VSTR</td>
<td>2005/13</td>
<td>25%</td>
<td>$16m</td>
<td>$8.5m</td>
<td>2</td>
<td>$147m</td>
<td>$12m</td>
<td>12.25</td>
</tr>
<tr>
<td>ANZICS</td>
<td>2005/13</td>
<td>80%</td>
<td>$16m</td>
<td>$9.8m</td>
<td>2.5</td>
<td>$45m</td>
<td>$11m</td>
<td>4.2</td>
</tr>
<tr>
<td>ANZDATA</td>
<td>2004/13</td>
<td>100%</td>
<td>$6m</td>
<td>$8.8m</td>
<td>0.3</td>
<td>$2m</td>
<td>$8.8m</td>
<td>0.2</td>
</tr>
<tr>
<td>AOANJRR</td>
<td>2003/14</td>
<td>100%</td>
<td>$6m</td>
<td>$13m</td>
<td>0.5</td>
<td>$6m</td>
<td>$13m</td>
<td>0.5</td>
</tr>
</tbody>
</table>

*Crude estimate. Likely overestimate due to assumption of starting from zero coverage in other states. In reality, there is some existing coverage with different definitions of "major trauma" (BCR - Benefit-Cost Ratio)
How can Clinical Trials Networks help?

CTNs: Economic evaluation

- Evaluated the economic impact of late phase, investigator-initiated clinical trials conducted through three Australian clinical trials networks
- Findings:
  - Significant net positive returns on investments and positive benefit to cost ratio
  - Substantial benefits – from better health outcomes and avoided service costs
  - Increasing implementation of trial evidence into practice can lead to considerable health and economic gains
## Selected Clinical Trials Networks

Represent over a third of completed trials, and a broad selection of clinical services.

<table>
<thead>
<tr>
<th>Network (Network)</th>
<th>Years of operation</th>
<th>Studies (Published</th>
<th>Funding</th>
<th>Publications</th>
<th>Number of trials included</th>
<th>Names of trials included</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australasian Stroke Trials Network (ASTN)</td>
<td>19</td>
<td>40</td>
<td>Published 35 current</td>
<td>&gt;$50m total $10m NHMRC</td>
<td>180+</td>
<td>7</td>
</tr>
<tr>
<td>Interdisciplinary Maternal and Perinatal Clinical Trials Network (IMPACT)</td>
<td>20</td>
<td>147</td>
<td>Published 150 current</td>
<td>$10-25m total $10m NHMRC</td>
<td>146</td>
<td>10</td>
</tr>
<tr>
<td>Australian &amp; New Zealand Intensive Care Society Clinical Trials Group (ANZICS CTG)</td>
<td>21</td>
<td>41</td>
<td>Published 28 current</td>
<td>&gt;$50m total $10m NHMRC</td>
<td>130+</td>
<td>8</td>
</tr>
</tbody>
</table>

### Significant International Impact

- **ARCH**: Clopidogrel plus aspirin versus warfarin in patients with stroke and aortic arch plaques. *Stroke* 2014; 45:1248-1257
- **AVERT**: Efficacy and safety of very early mobilisation within 24h of stroke onset (AVERT); a randomised controlled trial. *Lancet* 2015; 386: 46–55.
- **COIN**: Nasal CPAP or intubation at birth for very preterm infants: *N Engl J Med* 2008; 358:700-8
- **ACTOMGSO4**: Effect of magnesium sulfate given for neuroprotection before preterm birth: a randomised controlled trial. *JAMA* 2003; 290(20):2669-76
- **PPROMT**: Immediate delivery compared with expectant management after preterm prelabour rupture of the membranes close to term (PPROMT trial): a randomised controlled trial. *Lancet* 2015; 387: 444–4521
CTNs: Economic evaluation results

NOTE: Preliminary results

- Results if findings from the 25 trials are implemented in 65% of eligible patients seeking treatment in a year:

<table>
<thead>
<tr>
<th>Network</th>
<th>Gross benefit</th>
<th>Cost</th>
<th>BCR</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASTN</td>
<td>$1bn</td>
<td>$106m</td>
<td>9.5:1</td>
</tr>
<tr>
<td>IMPACT</td>
<td>$682m</td>
<td>$173m</td>
<td>3.9:1</td>
</tr>
<tr>
<td>ANZICS CTG</td>
<td>$271m</td>
<td>$57</td>
<td>4.8:1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$2bn</strong></td>
<td><strong>$336</strong></td>
<td><strong>5.8:1</strong></td>
</tr>
</tbody>
</table>

- Trial results only need to be implemented in 11% of the eligible patient population for benefits to exceed costs
- 9% of the gross benefit would break-even with all NHMRC funding awarded to all Australian clinical trials networks between 2004 to 2014*  

*As reported in the Profiling Networks Report

70% through better health outcomes

Prioritised list of clinical domains for clinical quality registry development

- The Framework includes prioritisation criteria based on:
  - Clinical relevance
  - Feasibility
- The project: To apply the prioritisation criteria and other elements in the Framework, to create a prioritised list of clinical domains for potential development of national clinical quality registries
Prioritisation criteria: Clinical need

1. There are serious consequences for the patient associated with poor quality care for the clinical condition or with poor quality of the device or procedure.
2. The condition, device or procedure of interest is associated with a high cost.
3. An evidence-based, well executed sequence of care improves patient outcomes for the clinical condition.
4. Unwarranted variation from this sequence of care can be identified and addressed.

Prioritisation criteria: Feasibility

5. The clinical condition is suited to clinical quality registry data collection:
   a. The relevant clinical population can be captured
   b. The clinical condition or event is able to be systematically recognised
6. There is clinician support for the clinical quality registry (or the proposed clinical quality registry)
7. The governance requirements for a successful clinical quality registry are in place
8. The information requirements for a successful clinical quality registry are in place
   a. An entire population with a chronic condition or disease, or who have undergone an acute event, can be captured
   b. There is a suitable data source
   c. Clinically meaningful performance indicators can be defined
   d. There is potential for reliable risk adjustment
9. There are sufficient resources available for the sustainable operation of the clinical quality registry
CQR: Prioritised list of clinical domains

- Application of the prioritisation criteria (and other elements) in the Framework, to create a prioritised list of clinical domains for potential development of national clinical quality registries
- The process combined available data with the collective judgement of experts.
- The ranking of the final priority list of clinical domains should be viewed as indicative, as the comprehensive data required to analyse objectively the relative performance of all short-listed clinical domains against all prioritisation criteria was not available

Methods – step 1

1. Identifying a short-list of diseases, conditions and procedures
   Identified a manageable list for further analysis based on:
   - Burden of disease (44 identified)
   - Cost to the health system (36 identified)
   - Survey of lay stakeholders (21 identified)
Shortlisting

- NHCDC data for cost with a cut-off of $0.1 billion was used >> 44 DRGs and DRG groupings considered.
- 2016 AIHW estimates of the burden of disease (2011 data) >> 36 conditions identified
- Stakeholder survey to identify any gaps from the cost and Burden of Disease analysis >> 21 conditions identified

Methods - Step 2

2. Application of the threshold criteria:
Short-listed diseases, conditions and interventions assessed against the threshold criteria of:
- Evidence based sequence of care (Criterion 1.2)
- Ability to identify and address variation from the sequence of care (Criterion 1.3)
- Suitability of the domain to clinical quality registry data collection (Criterion 2.1)
- Ability to meet the Information requirements for a successful registry (Criterion 1.2)

These threshold prioritisation criteria describe characteristics that were considered necessary for successful functioning of a clinical quality registry (using the framework criteria as a guide).
Application of threshold criteria

- existing evidence-based guidelines and/or literature defining an established sequence of care
- A qualitative assessment by the clinical group of ability to meet the criteria

Methods - Step 3

3. Grouping of diseases, conditions and interventions into clinical domains
The remaining short-listed diseases, conditions and interventions were systematically grouped into clinical domains.
Domains?

- Existing Australian clinical quality registries have developed organically in response to multiple drivers and vary with the level of focus from specific conditions and procedures to healthcare settings.
- An approach was adopted that grouped similar diseases, conditions and interventions to provide a structure of domains under which multiple registries may exist to avoid duplication of data collection.
- The priority and scope of the registries within each domain should be determined through further consultation with the relevant clinical groups.

Methods - Step 4

4. Prioritisation of clinical domains
These groups were assessed against the prioritisation criteria of:
- Serious consequence for the patient (Criterion 1.1)
- High cost to the health system (Criterion 1.4)
- Clinician support (Criterion 2.2)
## Prioritisation

<table>
<thead>
<tr>
<th>1.1: Serious consequences associated with poor quality care</th>
<th>1.4 – High cost to the health care system</th>
<th>2.2 – Clinician support</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of the total BoD – additional data was sourced for completeness</td>
<td>% of total cost in NHCDC</td>
<td>Based on level of development of clinical quality registry for the domain, clear leadership group, clinician advocacy</td>
</tr>
</tbody>
</table>

Five categories were chosen to represent broad grouping due to limitations of the data

Assessed by two senior Commission staff independently

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### Prioritised list of clinical domains

<table>
<thead>
<tr>
<th>Priority</th>
<th>Clinical domain</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Ischemic heart disease</td>
<td>Serious consequences of poor quality care, very high burden of disease and cost to the health system. Strong clinical support registries in this domain. Current national registries and potential to expand into non-surgical interventions in the future.</td>
</tr>
<tr>
<td></td>
<td>Musculoskeletal disorders</td>
<td>Serious consequences of poor quality care, very high cost and high burden domain. A number of national registries in hip and knee procedures, potential to expand to registries for non-surgical interventions in the future.</td>
</tr>
<tr>
<td>2</td>
<td>Trauma</td>
<td>Serious consequences of poor quality care, very high burden of disease and high cost to the system. Established leadership group and national registry with incomplete capture as well as jurisdictional registries.</td>
</tr>
<tr>
<td></td>
<td>Adult critical care</td>
<td>Serious consequences of poor quality care, very high burden of disease and cost. Existing leadership group and national registry for traumatic brain injury.</td>
</tr>
<tr>
<td>3</td>
<td>High burden cancers</td>
<td>Serious consequences of poor quality care, very high burden of disease and moderately high cost to the system. Strong leadership and a national registry.</td>
</tr>
<tr>
<td>4</td>
<td>Stroke</td>
<td>Serious consequences of poor quality care, very high burden of disease and cost to the system. Strong leadership and a national registry.</td>
</tr>
<tr>
<td></td>
<td>Renal disease</td>
<td>Serious consequences of poor quality care, very high burden of disease and cost to the system. Strong clinical support registries in this domain. Current national population based registers and potential to expand into non-surgical interventions in the future.</td>
</tr>
<tr>
<td>5</td>
<td>Neonatal critical care</td>
<td>Serious consequences of poor quality care, very high burden of disease and cost to the system. Strong clinical support registries in this domain. Current national population based registers and potential to expand into non-surgical interventions in the future.</td>
</tr>
<tr>
<td>6</td>
<td>Mental health</td>
<td>Serious consequences of poor quality care, very high burden of disease and cost to the system. Strong clinical support registries in this domain. Current national population based registers and potential to expand into non-surgical interventions in the future.</td>
</tr>
<tr>
<td>7</td>
<td>Maternity</td>
<td>Serious consequences of poor quality care, very high burden of disease and cost to the system. Strong clinical support registries in this domain. Current national population based registers and potential to expand into non-surgical interventions in the future.</td>
</tr>
<tr>
<td></td>
<td>Dementia</td>
<td>Serious consequences of poor quality care, very high burden of disease and cost to the system. Strong clinical support registries in this domain. Current national population based registers and potential to expand into non-surgical interventions in the future.</td>
</tr>
<tr>
<td></td>
<td>Major burns</td>
<td>Serious consequences of poor quality care, very high burden of disease and cost to the system. Strong clinical support registries in this domain. Current national population based registers and potential to expand into non-surgical interventions in the future.</td>
</tr>
<tr>
<td></td>
<td>Diabetes</td>
<td>Serious consequences of poor quality care, very high burden of disease and cost to the system. Strong clinical support registries in this domain. Current national population based registers and potential to expand into non-surgical interventions in the future.</td>
</tr>
</tbody>
</table>
Next steps

Commission work program

• To develop a view on the national policy context for CQRs (the Framework is the overarching guide)
  • Economic evaluation of CQRs
  • Economic evaluation of clinical trail networks
  • Develop a prioritised list of clinical domains
• Update the framework to clarify governance arrangements
• Pilot the framework
• Develop a standard for CQR (using the framework as the basis)
Update the framework to clarify governance arrangements

25. CQRs must formalise governance structures to ensure accountability, oversee resource application, provide focus and optimise output from the CQR.

26. CQRs must establish policies to manage a range of contingencies arising from the analysis of data from the CQR, which includes a formal plan ratified by the CQR Steering Committee to address outliers or unexplained variance, to ensure that quality of care issues are effectively addressed and escalated appropriately.

Existing arrangements for CQRs

<table>
<thead>
<tr>
<th>National</th>
<th>The Privacy Act 1988 (Section 95) including Information Privacy Principles [Applicable to Commonwealth agencies and the ACT. Not applicable to other States and Territories].</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private Health Sector</td>
<td>The Privacy Act 1988 (Section 95A) including National Privacy Principles [Applicable to all health service providers in the private health sector].</td>
</tr>
<tr>
<td>Australian Capital</td>
<td>Privacy Act 1986</td>
</tr>
<tr>
<td>Territory</td>
<td>Health Records (Privacy and Access) Act 1997</td>
</tr>
<tr>
<td>New South Wales</td>
<td>Health Records and Information Privacy Act 2002</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>Information Act 2002</td>
</tr>
<tr>
<td>Queensland</td>
<td>Information Privacy Act 2009</td>
</tr>
<tr>
<td></td>
<td>Health and Hospitals Network Act 2011</td>
</tr>
<tr>
<td></td>
<td>Private Health Facilities Act 1999</td>
</tr>
<tr>
<td></td>
<td>Public Health Act 2005</td>
</tr>
<tr>
<td>South Australia</td>
<td>Cabinet Administrative Instruction 1/89: Information Privacy Principles 1, 2 &amp; 3; Code of Fair Information Practice</td>
</tr>
<tr>
<td>Tasmania</td>
<td>Personal Information Protection Act 2004</td>
</tr>
<tr>
<td>Victoria</td>
<td>Health Records Act 2001</td>
</tr>
<tr>
<td></td>
<td>Health Services Act 1988</td>
</tr>
<tr>
<td></td>
<td>Mental Health Act 1989</td>
</tr>
<tr>
<td>Western Australia</td>
<td>Hospital and Health Services Act 1927</td>
</tr>
</tbody>
</table>
Governance update

- Mechanisms for data access for funders, researchers, government and consumers - ? Model of access similar to SURE
- National ethics arrangements / National data agreements
- Jurisdictional Reporting
- Outlier management
- Public reporting and transparency
- Linkage to other national datasets
  - Births, deaths and marriages
  - National Inpatient Data
  - MBS and PBS
  - Social determinants from census
National infrastructure model

SURE, the Secure Unified Research Environment, is a secure computing environment that Australian researchers can log in to remotely to analyse linked health data. SURE will boost Australia’s capacity for national and international large-scale research collaborations. It will allow faster analysis and greater storage capacity for researchers dealing with large data files.
Develop the framework into a standard

Set minimum requirements
• Demonstrated clinical need
• Purpose and scope
• Organised clinical leadership and governance
• Indicators
• Data Set Specification (METeOR, AIHW)
• Data collection (succinct, not overly burdensome)
• Data quality (accuracy and ascertainment)
• Data custodianship (jurisdictional, private sector, NHIA)
• Ethics and privacy
• Reporting (routine and ad-hoc to funders, jurisdictions, clinicians, healthcare organisations etc.)
• Certification of secure data hosting (technical) services

Possible models
• Self assessment
• Accreditation or certification to an endorsed peer committee, organisation or similar
• Establishment or designation of a publicly accountable agency
Emerging issues

- Outlier management
  - Jurisdictional oversight
  - Community assurance
  - AHPRA revalidation
- Integration with eMR
  - Avoidance of duplicate data collection and entry
  - Real time feedback
- Global PROMs and QA
  - Understanding what is being done to whom and the outcomes
  - Health vs Toyota or Apple…

Medical Research Future Fund

- The Medical Research Future Fund was established in August 2015 via an act of Parliament. The Fund is a financial asset fund and represents an endowment that will support medical research and innovation into the future.
  - The Fund will provide a predictable funding stream for medical research and innovation into the future with the credits to the Fund preserved in perpetuity. The capital of the Fund will be invested, with earnings used to make grants of financial support to medical research and innovation over the long term.
Medical Research Future Fund

The Priorities - The Strategy identifies six Strategic Platforms

1. Strategic and international Horizons
2. Data and Infrastructure
   This Platform seeks to make better use of existing data and infrastructure. Priorities are: clinical quality registries; research with other agencies to identify how we can better utilise the MyHealth Record and linked health and social data for research; a consumer-driven health and research agenda; developing the means to measure and report on the economic returns from the MRFF’s investments; and research on the surveillance of and response to current and emerging infectious diseases and antimicrobial resistance.

3. Health Services and Systems

4. Capacity and Collaboration

5. Trials and Translation
   Priorities under this Platform are: support for new and existing national clinical trial networks; extending clinical trials of proven therapies with limited commercial potential to at-risk groups; and working with the NHMRC-accredited Advanced Health Research and Translation Centres to support the translation of research in key areas including clinical variation, co-morbidity and health inequity.

6. Commercialisation
Medical Research Future Fund

- Impact measurement
  - Better patient outcomes
  - Beneficial change to health practices
  - Evidence of increased efficiency in the health system
  - Commercialisation of health research outcomes
  - Community support for the use of and outcomes from funding

Consultation on Secondary Use of My Health Record Data
Postponed

The department has decided to postpone the consultations until early next year. There are a number of other consultations occurring at this time, for example on the National Digital Health Strategy, that will compete for the attention of health care providers and the broader community. In addition it is possible that the outcome of these consultations could further inform a discussion paper on secondary use of My Health Record data. The department apologises for any inconvenience caused and will ensure the dates are advertised and a consultation paper is released well in advance of the consultation sessions.
What good looks like?

hypothetical example of deaths following cardiac surgery

number of cardiac surgery cases in the past year

percentage of patients who died

HOSPITALS WITH AN UNEXPECTEDLY HIGH PROPORTION OF DEATHS

HOSPITALS WITH AN UNEXPECTEDLY LOW PROPORTION OF DEATHS

The Long Room in the old library (1712) – Trinity College, Dublin (1592) (Doomsday Book 1086) (Oxford University 1096)

Questions?