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Dear Margaret

Thank you for the opportunity to provide a submission to the Australian Commission on Safety and Quality in Health Care's Discussion paper on National Safety and Quality Accreditation Standards. Thank you also for the opportunity to provide feedback to the Commission during the consultation forums held in February and March. On behalf of the Australian Private Hospitals Association (APHA), I have attached a submission that addresses the questions posed in the Discussion paper and also canvasses a range of relevant issues.

As you are aware, APHA is the peak national body representing the interests of the private hospital sector, with a diverse membership that includes large and small hospitals and day surgeries, for profit and not for profit hospitals, groups as well as independent facilities, located in both metropolitan and rural areas throughout Australia. The range of facilities represented by APHA includes acute hospitals, specialist psychiatric and rehabilitation hospitals and also free-standing day hospital facilities.

You may also be aware that current accreditation is a condition of membership of APHA.

Please contact me if APHA can assist the Commission further on this important matter.

Yours sincerely

Michael Roff  
Executive Director  
31 March 2007

# **SUBMISSION BY THE AUSTRALIAN PRIVATE HOSPITALS ASSOCIATION TO THE AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE'S DISCUSSION PAPER ON NATIONAL SAFETY AND QUALITY ACCREDITATION STANDARDS**

## **Background**

The Australian Commission on Safety and Quality in Health Care has been tasked by the Australian Health Ministers' Advisory Council to undertake a review of accreditation arrangements. As part of the consultation process for this review, the Commission has released a Discussion Paper for comment.

The APHA Safety and Quality Committee has distributed the Commission's Discussion paper to the APHA membership and has sought the views and comments of the diverse range of facilities represented by the Association. APHA is aware that a number of private hospital groups and individual facilities have provided submissions on the paper to the Commission. As this submission has been overseen by the APHA Safety and Quality Committee it should be taken as representing the views of the 75% of the private hospital sector represented by APHA.

## **General points on the Discussion paper**

APHA notes that the Discussion paper does not attempt to assess the Australian Council on Healthcare Standards (ACHS) or other accreditation agencies as service providers or ACHS EQUIP or ISO 9000 series as sets of standards, nor does it compare these to each other in any detailed sense.

Rather, the paper picks up on disparate criticisms of the current accreditation systems such as: cost, inter-rater (surveyor) reliability, complexity, gaps, duplication, and lack of standardisation and then appears to take as its starting point that the current accreditation system will not meet the needs of the health system in the future and that it therefore requires replacing with an alternative model. For example, on page 23 the paper argues that: "*fundamental changes are required to sustain accreditation and to address concerns with the existing system.*"

Health Ministers tasked the ACSQHC in part to outline the "strengths and weaknesses of the current system", however, the paper focuses its attention on the perceived weaknesses. This approach leads towards a case supporting fundamental reform whereas a more balanced approach that takes account also of the strengths of the current system (as requested by Ministers) would have been more likely to support a case for incremental reform.

The paper distinguishes between the development of standards and the accreditation process and identifies a series of issues relating to each of these activities and identifies several proposed reforms to both the accreditation process and standards

setting. As noted above, the current system appears to be regarded as requiring replacement and therefore the status quo is not considered as an option for the future.

Of considerable concern to APHA is that the reform proposals are not tested in any detailed way against the perceived shortcomings of the current system. While it is possible that the reforms could lead, for example, to greater standardisation, it is not clear that complexity would necessarily be reduced or that gaps in accreditation would be addressed and in APHA's view, it is highly likely that the proposed reforms would come at a higher cost than the current system.

While an assessment of the costs of a reformed system of accreditation was not specifically requested by Health Ministers, APHA argues that a complete assessment of any options for reform must be informed by an indication of their costs and, in particular, by an understanding of those areas where any cost increases will impact.

None of this discussion should be taken to imply that APHA believes that the current accreditation and standards development systems do not require reform – clearly, the current systems have serious problems that must be addressed. However, APHA does not accept that the complete dismantling of the current system and its replacement with largely untested alternatives is an appropriate response.

In APHA's view, the safety and quality of health services is a shared endeavour of providers (institutions and practitioners), funders and governments with the objective of providing optimal outcomes for consumers/patients. Accordingly, the system of accreditation of health services should ideally be shaped around this shared responsibility.

APHA is concerned that the Terms of Reference for this Review by the ACSQHC are too narrow to take sufficient account of the duplication, overlap, waste and inefficiency caused by the wider regulatory environment around quality assurance of which accreditation is one part. APHA is most concerned at the ever increasing costs of compliance imposed on private hospitals to meet the requirements of State licensing; State-based safety and quality bodies such as the Queensland Quality and Complaints Commission; and private health insurance funds, in addition to accreditation agencies, all of which are seeking to undertake the same task, assuring the safety and quality of health services.

For example, ACHS have a mandatory standard for credentialing, the Queensland Private Hospitals standards require credentialing processes which were audited in 2006, each of the health insurance funds require compliance with, and reporting on, standards for credentialing and the Health Quality and Complaints Commission recently released a draft standard for Credentialing. While each of these entities reference the Credentialing and Scope of Clinical Practice standard, each have different reporting requirements. This is wasteful and inefficient and is but one of a plethora of overlapping requirements imposed on private hospitals for no clear end.

Any reform of accreditation and standards setting must set as its priority to grapple with and resolve the two key failings of the current regulatory oversight of safety and quality of health services: the wasteful duplication and overlap in some parts of the

health sector, particularly the private hospital sector; and the gaps in the accreditation of many out-of-hospital health services.

## **The Commission's questions**

APHA's comments against each of the questions posed in the Commission's Discussion paper are set out below.

### **Accreditation Issues**

#### **1. Effectiveness in identifying poor performance**

##### **✍ What core processes or systems need to be in place to ensure poor performance is detected? Is this necessarily part of an accreditation process?**

Failures in performance of a health care organisation would be expected to be detected (and remedied) by the policies, processes and check-points in place in the facility. The accreditation process assists in evaluating whether these systems are in place, how effectively each is working and the extent to which each meets best practice benchmarks.

##### **✍ Where there is a systems failure, how should the accreditation body respond?**

The facility and its owner should be immediately informed where a systems failure is identified and a date agreed by which the failure should be rectified. The seriousness of the systems failure would guide the response by the accreditation agency.

#### **2. Transparency**

##### **✍ What is essential to ensuring all accreditation processes are open and transparent?**

The development of the standards used to assess the performance of health care organisations should be completely open and transparent with genuine consultation facilitated by the standards development body.

The accreditation process itself should be completely transparent to the facility and to its owner with any issues identified and fully discussed as part of the process. This requires appropriate selection and training of surveyors, a commitment by the accrediting body to robust processes that are clearly understood by all health care organisations and the maintenance of a culture of openness and trust.

✍ **What minimum information should be publicly available on the accreditation status of health services?**

Publication of information on the accreditation status of health services is the responsibility of the health care organisation and its owner and should be prominently displayed on the organisation's website and/or in the facility itself. The following information should be publicly available on the accreditation of health services:

- ✍ Whether a service is accredited
- ✍ The expiry date of accreditation
- ✍ An accreditation statement developed by the facility and its owner

### **3. Governance**

✍ **What governance issues must be addressed by organisations setting standards, training surveyors or accrediting health services?**

In APHA's view, governance is critical to the accreditation process. Accrediting bodies must themselves be subject to regular accreditation to ensure that their processes are robust, transparent and effective.

APHA does not believe that there is necessarily any inherent conflict where an independent accrediting body also develops standards. Indeed, this relationship can contribute to the development and maintenance of standards that are relevant and meaningful and can also contribute to the collection and analysis of a range of relevant data that can be fed back to health services for benchmarking purposes.

However, the potential for conflict is much more likely where funding bodies (private or public) develop, impose and measure compliance with their 'standards'. In these circumstances it is much more difficult to ensure independence and transparency of the accreditation process. In addition, funding bodies (private or public) are very rarely themselves accredited.

### **4. Duplication and Overlap**

✍ **What needs to be done to integrate and streamline overlapping accreditation processes?**

A central element of any reform of the accreditation systems and processes must seek to alleviate the current burden imposed by disparate requirements of government (State and Federal); accreditation agencies; State-based Safety and Quality agencies; and funders, in particular, private health insurance funds. Rather than a shared endeavour, each of these imposes its own set of requirements to achieve the same end objective of safe and quality health services. The current system of ensuring the safety and quality of health services, of which accreditation is a key component, is anything but systematic characterised as it is by duplication and inefficiency.

Service providers such as private hospitals face ever increasing (and un-recouped) costs of compliance to meet the continued regulatory creep whereby governments, State-based Safety and Quality agencies (such as the Queensland Quality and Complaints Commission); and private health insurance funds each develop and impose their own 'standards' which in many cases overlap and duplicate the requirements of accreditation agencies. A recent assessment indicates that some 900 pieces of legislation, regulation and standards may impact private health care organisations.

Therefore, while integrating and streamlining overlapping accreditation processes is important, the benefits will not accrue unless the approach is broadened to include other regulatory, funding and contractual requirements that purport to ensure safety and quality.

The APHA Safety and Quality Committee has coordinated an assessment of the requirements imposed on private hospitals by health insurance funds to collect and report data relating to safety and quality. The results of this assessment are included in the confidential attachment. As the data has been provided to the APHA Safety and Quality Committee in confidence, APHA provides it in confidence for the information of the ACSQHC as an indication of the burden imposed by this duplication of existing accreditation processes.

Of particular concern is that this duplication and overlap, far from ensuring safer and higher quality health care, actually has the reverse effect by redirecting scarce resources (staff and financial) away from the provision of health care to comply with administrative requirements.

Any reform of accreditation must at the outset grapple with this duplication and waste of resources. A partnership approach, whereby the award of accreditation is recognised as a marker of safe and quality health services would be a good starting point.

It should be noted that the hospital sector (private and public) is arguably over-regulated with the myriad of overlapping regimes outlined above. This is in stark contrast to the lack of regulation of many out-of-hospital services which, through advances in technology, can and do now involve a wide range of services and procedures. This gap in accreditation of out-of-hospital services requires urgent attention.

## **5. Resource requirements**

### **✍ How can accreditation be made more cost efficient and effective?**

The points made above in relation to duplication and overlap are very relevant here. The elimination (or at least minimisation) of duplication would be positive step towards improving the cost effectiveness of accreditation.

In addition, standards developed for specific types of facilities, such as mental health facilities (National Standards for Mental Health Services) should be integrated into

existing accreditation processes instead of added as extra modules (at additional cost) as is currently the case.

Documentation is another area that has great potential for streamlining. All pieces of documentation required as part of the accreditation or pre-accreditation process should be regularly evaluated to ensure that each remains critical and relevant.

## **6. Surveyors**

### ***✍* What must be done to ensure inter-surveyor reliability?**

Attention is required to the selection processes for surveyors and team leaders. Team leaders perform a key role in the accreditation process and APHA believes that improved processes are required to ensure that appropriate individuals are identified and appointed to these key positions. A straightforward measure that could be immediately adopted is the introduction of confidential assessments by surveyors of the performance of the team leader. These assessments would be programmed shortly after a survey and undertaken on a random basis.

Training of surveyors and team leaders needs to be ongoing. This training must encompass an understanding of the differences between various parts of the health sector and how these differences are accommodated within the standards and the accreditation processes.

Improved oversight is required to ensure that surveyors are surveying health services against the standards and are not influenced by their personal views and background. The point above in relation to the regular and random assessment of team leaders would assist here.

### ***✍* What strategies need to be put in place to ensure there is available a sustainable supply of credible and competent surveyors?**

The point made above in relation to the regular and random assessment of team leaders is also relevant here.

An important strategy would be the recognition by funders that the release of staff for training and participation in surveys is an indication of a private health care organisation's commitment to improving safety and quality in the sector and that it comes at a cost to the health care organisation. Many private hospitals and groups face considerable logistical difficulties in making an ongoing commitment to release their senior staff to participate as surveyors.

Funders could be encouraged to consider providing incentives to organisations to release senior staff for selection and training as surveyors.

## **7. Information to support accreditation**

### **✍ What needs to be in place to allow accreditation data to be collected at a national level?**

Inter-rater reliability needs to be greatly improved prior to any consideration of the collection of accreditation data at a national level. The rationale for the data collection and its intended purposes would need to be clearly identified and agreed with private health care organisations prior to its collection at the national level.

### **✍ What needs to be in place to allow accreditation data to be made available?**

The type of information to be made publicly available would need to be agreed with private health care organisations. Much greater trust than currently exists would need to be engendered between accrediting bodies and private health care organisations.

Much greater effort must be allocated to the education of media organisations and key journalists to ensure that any data that is made publicly available is clearly understood as to its meaning, its limitations and the reasons why the data is being released.

## **Standards Issues**

### **1. Proliferation of Standards**

#### **✍ What initiatives are required to coordinate and harmonise standards development?**

The comments made earlier in relation to duplication and overlap have equal relevance here.

A national approach to standards development would be required which would include the development of agreed core principles for accreditation that would be articulated and underpinned by standards. All standards should be mapped against these core principles to assess the relevance, usefulness and effectiveness of existing standards and to identify gaps.

### **2. Access to standards**

#### **✍ What minimum information should be publicly available on accreditation standards?**

All accreditation standards should be publicly available, free of charge. This would assist in a greater understanding of the accreditation process and permit transparent assessment of the robustness and relevance of the standards.

### **3. Process of developing standards**

#### **✍ What aspects of Australian health care standard development should be standardised for more streamlined, effective and efficient standards development?**

As noted earlier, a national approach to standards development would be required which would include the development of agreed key principles for accreditation that will be articulated and underpinned by standards. All standards should be mapped against these core principles to assess the relevance, usefulness and effectiveness of existing standards and to identify gaps.

### **4. Appropriateness of standards**

#### **✍ How do you ensure the standards being assessed are appropriate?**

A one-size-fits-all approach is not an appropriate mechanism to underlie the development of standards.

Appropriateness is determined by the degree of understanding by the responsible organisation and the individuals developing the standards regarding the critical differences between different elements of the health system and a willingness to accommodate these differences within the scope, articulation and measurement of particular standards. This understanding can be enhanced by the participation of representatives from different parts of the health sector in the standards development process.

## **Accreditation Reform Strategies**

### **1. Register of accrediting bodies**

#### **✍ What needs to be in place to make this approach feasible?**

The register would need to be national in scope and be conducted by an independent organisation. Ideally funding would be provided by government. Transparent and consistent criteria for listing on the register would be necessary and it would be expected that information contained on the register would be restricted to relevant details on each accrediting body and its accreditation system and processes.

APHA understands that the ACSQHC is currently undertaking an assessment of registers and the development of a register of accrediting bodies would be informed by the outcomes of this assessment.

#### **✍ Which organization is best placed to manage the registration of accreditation bodies?**

APHA is not aware of any particular body that would be best placed to undertake this task although the assessment of registers by the ACSQHC may provide some

guidance. Alternatively, a body could be auspiced by the Australian Health Ministers Advisory Council, together with appropriate private sector input. If this course of action is pursued, this body would need to be completely independent.

## **2. Standardise accreditation language and definitions**

### **✍ Who needs to be involved in the standardisation of language and definitions?**

Standardisation is almost always a worthy objective. The various committees that contribute to the updating and maintenance of the Health Data Dictionary, such as the Health Data Standards Committee, would be worth consulting in the first instance to gauge their capacity to be involved in the standardisation of accreditation language and definitions.

In addition to inclusion in the Health Data Dictionary, the standardised accreditation language and definitions should be widely disseminated and included in the proposed Register of Accrediting Bodies and in every standards collection.

## **3. Training and competency testing of surveyors**

### **✍ What are the essential skills, competencies and attributes that surveyors need?**

Surveyors should:

- ✍ Be excellent communicators
- ✍ Be open and collegiate in their approach
- ✍ Have current health care experience
- ✍ Have the capacity to see beyond their personal health care experience
- ✍ Have a willingness and capacity to learn
- ✍ Have good listening skills
- ✍ Have a clear, consistent and analytical approach to surveys
- ✍ Be flexible and adaptable

### **✍ What needs to be in place to train and assess surveyors effectively?**

- ✍ Nationally consistent competencies need to be identified and agreed
- ✍ Core training products and processes need to be developed
- ✍ Regular assessment of training processes and materials needs to be undertaken
- ✍ Reduction (ideally elimination) of subjective language from all standards, elements and criteria
- ✍ As discussed on page 6, the active support of funding bodies would assist here

#### **4. Better use of data for evaluation of health service performance**

##### **✍ How can the available data sets be best used to inform accreditation processes?**

APHA agrees that the current approach to data collection is somewhat fragmented, however, it is unclear how available data sets might better inform accreditation processes. If the intention is to access identified data and cross-match data sets, the privacy implications would need to be thoroughly and publicly assessed and the individuals and the organisations that are the subject of the data would need to be actively consulted.

#### **5. System wide accreditation against safety and quality standards**

##### **✍ Which health services should be accredited as a priority, and how can this be best achieved?**

ALL health services should be accredited as a priority. The fact that gaps exist in the accreditation of many health services beyond the hospital sector is an indictment of the failure of the current regulatory environment.

The Federal Government's reforms to private health insurance to permit health insurance benefits to be paid for out-of-hospital services will exacerbate the shortcomings of the current environment. The Government expects to have in place a 'uniform' system of quality assurance for all privately insured services by 1 July 2008. However, APHA is most concerned that there is no attention paid by the Government to the quality and safety regime that is to apply for the 15 month period from 1 April 2007-30 June 2008 for these new services.

There is nothing in the legislation (Private Health Insurance Act 2006) or in any of the consultation documents released by the Department of Health and Ageing that offers any comfort to APHA that there is an understanding at the Federal level of the current accreditation system for hospital-based services, nor the nature of the relationship between admitting doctors and private hospitals, including credentialling and defining the scope of practice, nor to the complex system of liability insurance.

In particular, it appears the legislation makes an artificial distinction between the accreditation of facilities and the qualifications of service providers. The gap created by this distinction is the lack of any requirement for accreditation of 'services'. That is, while there are some elements of current hospital accreditation requirements that go to facilities (such as physical environment, fire safety, waste management etc.) the fundamental purpose of accreditation is to ensure compliance with standards and continuous quality improvement of the services provided within that facility.

Specifically, ensuring a practitioner is qualified gives no guarantee of the quality of a program or service delivered, in whole or in part, by that practitioner.

APHA has proposed to the Government (unsuccessfully to date) that the uniform safety and quality requirements apply to organisations, facilities, service providers

(practitioners) and services. This is particularly relevant when many of the services proposed to be covered by the new products would not necessarily be delivered within a ‘facility’.

APHA contends that any accreditation requirement must apply to all services funded by private health insurance (including for example, telephone advice lines) in both the public and private sectors.

Furthermore, APHA strongly opposes any ‘reforms’ that would put in place a multiplicity of quality and safety requirements that are determined by each individual health insurance fund. This is neither efficient nor effective.

Accreditation is a pre-requisite for membership of APHA.

## **6. Introduction of unannounced surveys**

### **✍ What needs to be done and by whom, to introduce unannounced surveys in a timely and effective way?**

APHA believes that thorough piloting of unannounced surveys is a prerequisite to their introduction into the accreditation process. Piloting across a representative range of settings would assist in the evaluation of the capacity of unannounced surveys to enhance the accreditation process. Piloting would also provide an opportunity to address the view that unannounced surveys are a punitive device.

A transparent and well-understood framework and consistently applied criteria for the use of unannounced surveys would need to be developed and agreed with private health care organisations prior to its introduction. An assessment would also be required of any service environments (for example mental health services) that may be unsuitable settings for unannounced surveys.

There would be some capacity to learn from the experience of the aged care sector in the use of unannounced surveys.

## **7. Introduction of Tracer Methodology in external accreditation reviews**

### **✍ What needs to be done and by whom, to introduce tracer methodology in a timely and effective way?**

In APHA’s view, the case for the adoption of tracer methodology has not been made. There has been no thorough evaluation of its utility, strengths and weaknesses following its introduction in the United States. Furthermore, Australia’s complex, silo-based healthcare funding and service delivery may add a layer of difficulty for the adoption of tracer methodology in the accreditation process. In any event, thorough piloting across a representative range of health care settings is a prerequisite to any introduction of tracer methodology.

As noted above in relation to unannounced surveys, a transparent and well-understood framework and consistently applied criteria for the use of tracer methodology would need to be developed and agreed with private health care organisations prior to its

introduction. An assessment would also be required of any service environments that may be unsuitable settings for tracer methodology.

## **Standards Reform Strategies**

### **1. Registrations of sets of health care standard**

#### **✍ What needs to be in place to make this approach feasible?**

Comments made earlier in relation to the proposed Register of Accrediting Bodies are also relevant here.

The register would need to be national in scope and be conducted by an independent organisation. Ideally funding would be provided by government. Transparent and consistent criteria for listing on the register would be necessary.

#### **✍ Which organization is best placed to manage the longer term register of standards?**

APHA is not aware of any particular body that would be best placed to undertake this task although the assessment of registers by the ACSQHC may provide some guidance. Alternatively, a body could be auspiced by the Australian Health Ministers Advisory Council, together with appropriate private sector input.

As recommended earlier, APHA believes that all standards should be publicly available free-of-charge, therefore the choice of organisation to manage the register of standards should be considered carefully.

### **2. Harmonisation of health service standards**

#### **✍ What are the barriers to standardization of language and definitions?**

An agreed process would need to be established for undertaking the standardisation of language and definitions.

It is possible that the ‘ownership’ of a range of standards by some standards-setting bodies may present some obstacles to the standardisation of language and definitions, although these should not be insurmountable.

#### **✍ Who needs to be involved in this standardisation process?**

The various committees (such as the Health Data Standards Committee) that contribute to the updating and maintenance of the Health Data Dictionary, together with representation from the ‘owners’ of the standards. It would be appropriate for the ACSQHC to oversee this process.

### **3. Detailed mapping of standards**

#### **✍ Who needs to be involved in this mapping process?**

The mapping process needs to be comprehensive and holistic and must encompass the entire range of standards and regulation that impinge on accreditation. The Commission's Inter-Jurisdictional Committee, the Information Strategy Committee and the Private Hospital Sector Committee could jointly commence this process, with input from standards-setting bodies. This process would be a useful means of addressing duplication and overlap.

### **4. Identification of core safety and quality areas**

#### **✍ What priority areas should be included in core safety and quality standards?**

As a prerequisite, the purpose of accreditation needs to be canvassed and agreed. Following agreement on the purpose of accreditation, core principles could be identified and agreed by all stakeholders.

As a starting point, core safety and quality standards could be constructed around the core priorities of the ACSQHC, including:

- ✍ Hygiene
- ✍ Medication safety
- ✍ Patient identification
- ✍ Handover
- ✍ Open Disclosure

### **Mutual Recognition of Standards and Accreditation Processes**

#### **✍ What is required to implement mutual recognition of standards and accreditation process in the Australia health care system?**

Duplication and overlap must be addressed as prerequisite to mutual recognition of standards and accreditation processes. If this does not occur first, there will be difficulties encountered as it would be a very complex task to assess the equivalence of standards developed and applied by governments, State Safety and Quality agencies and private health insurers.

A partnership approach, coordinated by the ACSQHC would bring together State and Federal Governments, State-based Safety and Quality agencies, private health insurance funds and service providers to canvass the issues around mutual recognition of standards and accreditation processes.