

29 March 2007

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Australian Commission on Safety and Quality in Health Care  
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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.

Attached is UnitingCare Health's submission that addresses the questions posed in the Discussion paper.

Please note that UnitingCare Health has been actively involved in the preparation of the submission by the Australian Private Hospitals Association, and their submission is therefore strongly supported by UnitingCare Health.

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

Yours sincerely

A handwritten signature in black ink, appearing to read "R. Royle", is written over a light blue horizontal line.

**RICHARD ROYLE**  
Chief Executive Officer

## **DISCUSSION PAPER ON NATIONAL SAFETY AND QUALITY ACCREDITATION STANDARDS: AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE**

### **General Issues**

The Commission's Discussion paper is concerned with accreditation in general – that is, accreditation of hospitals (private and public), mental health services, general practice, community health services etc. However, the burden of compliance with standards for private hospital providers extends well beyond Accreditation with licensing, health fund, hospital insurer and statutory entities establishing and reviewing standards. The burden created as a result of standards duplication is further compounded by state variations for national providers

A number of these entities may establish similar standards, with entity-specific variations which result in resource demands (personnel and financial) for compliance.

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 funds and hospital insurers 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.

With the scope of the review limited to Accreditation programs (excluding Aged Care), it is difficult to identify what the benefits of amending or replacing the existing system is without reform to the broader concerns related to standards setting given the resource implications of any change on the industry. It is also difficult to identify how the extent of duplication can be analysed without broadening the scope of the review to all agencies that establish quality and safety standards.

It is therefore seen as vitally important that discussions around accreditation programs are specifically broadened to review the requirements of all agencies that establish quality and safety standards.

The Discussion paper implies that fundamental change to the existing system is required however does not provide an objective analysis of the issues and appears to be drafted with a pre-determined outcome already in mind. Systems have been established to manage Accreditation, understand language and familiarity with processes. Complete change of this system would create substantial initial resource demands, education in new requirements and introduction of a new "quality language". Any benefit of substantive change would need to outweigh the cost of implementation.

The paper provides limited evidence to support the discussion and recommendations and does not provide supporting evidence, alternative options or identify the implications of any change within the industry. As a result of this, providing an informed response for some of the questions is difficult.

The size and scope of services provided within the health industry vary significantly. Developing a single standards framework that is general enough to apply to all services but specific enough to define requirements and advance safety and quality would be difficult, if not impossible, to achieve, however appears to be an underlying premise of this paper.

Having private providers that establish and review standards provides a mechanism for this that is independent of government intervention. The current system allows for some degree of a barrier to be established to minimize standards development becoming a political tool to address the latest issues being raised by the media.

Acknowledging that there are significant concerns with the skill and consistency of Surveyors, the current system of having senior staff who are working with the industry provides a mechanism of engaging senior staff in quality management processes and supports the sharing of strategies between service providers for improving care and service outcomes more broadly within the industry. Consideration should be given to retaining this in some form as a mechanism for engaging staff to be leaders in quality.

## **Response to Questions**

### **Accreditation Issues (pages 14-19)**

#### **1. Effectiveness in identifying poor performance (page 14)**

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

For quality service and care outcomes to be achieved, mechanisms to detect errors and poor performance should be a service provider driven requirement. A range of strategies are required which should include internal and external review processes however no single strategy could detect all systems failures within health care facilities. Improving funding for quality activities that support providers to implement systems would achieve greater improvements in care outcomes than wholesale change of Accreditation systems.

The nature of the Accreditation process and the requirement to maintain Accreditation to meet licence and funding obligations results in organisations presenting organisational performance information in the best possible light. . Examples of regional director performance being linked to Accreditation results have also been communicated from jurisdictions within Australia. As a result of this, where organizations are performing poorly it is unlikely that this will be openly communicated to Surveyors as the impact of non-accreditation is significant. Mechanisms to safely report and action poor performance, while not compromising patient safety and organizational viability, are required for improving open and transparent performance review.

An on-site review once every two years for an average of 2 – 4 days can only provide a review of a small percentage of organizational activities. It is unreasonable to expect that all poor performances would be detected by an external reviewer in this timeframe, as the ability to detect poor performance is dependent on being able to observe poor practice and/or analyse information provided prior to and during the survey.

For poor performance to be detected from an external review, the ideal would be to have surveyors with expertise in every system being reviewed, or increase the time allocated to undertake surveys so that a representative sample of staff are interviewed and documents reviewed. It would be impractical for a survey team to have in depth knowledge in every standard being reviewed and extending the time of surveys would have resource implications for both the Accrediting entity and the organization being reviewed.

For the credibility of Accreditation findings, it is critical that there is consistent interpretation and application of standards industry-wide and clear guidelines provided on requirements for compliance with standards to improve credibility of the Accreditation process. Improving the training of surveyors in auditing skills and validating evidence sought by Surveyors would assist with more objective performance review.

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

The paper provides little guidance on what would constitute a 'systems failure' so makes an informed response difficult. A 'systems failure' could range from non-patient impacting failures, such as a policy being out of date to the lack of structured outcome review where patient outcomes data is not analysed and causes of poor outcomes not addressed

The current system allows for a number of options for responding to system failures. Surveyors can a) make recommendations and award full accreditation; b) award limited accreditation; c) award non-accreditation of the organization. There should be scope for the accreditation body to respond according to the nature of the systems failure and the patient care impact and the current ACHS options allow for this. The key focus for improvement should be to ensure that there is industry-wide consistency and transparency with how response options are applied. Organisations should be provided with an appropriate opportunity to provide feedback on findings and recommendations.

## **2. Transparency (pages 14-15)**

This discussion point notes "as identified by stakeholders" – it would be beneficial to understand who these are and what the issues are as there is only very general reference to this.

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

Consumers are seeking more information about quality health care and services – particularly with use of the internet to learn about disease processes, surgery options etc. It is however unclear what level of information on Accreditation is sought by consumers and whether this is a key factor in determining hospital selection. Hospital selection is frequently based on where the treating medical practitioner refers them, or the geographic location of the facility and services provided. Significant community education would be required as to what the standards mean, the process involved, how to read results and the benefits to their own health service which would require significant resources for such a campaign.

Addressing the lack of understanding of what recommendations mean, particularly if recommendations are noted to assist the organization to continue to improve rather than in response to deficits, would be required before publishing detailed reports. This would be required to be addressed for the community in general, but specifically for the media who, from recent Australian experience, have consistently interpreted ACHS data and sentinel event reports in a very negative way.

For accreditation results to be published, there also would need to be improved consistency with how standards are interpreted to support comparison of results and a process to allow for existing skills and knowledge differences amongst surveyors to be addressed. A process for organizations to provide an update to published information, for example recommendations would also be required.

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

If there is improved access to standards, skills development for Surveyors and consistency in interpretation of standards, Accreditation status should be all that is required to be noted.

### **3. Governance (pages 15-16)**

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

Providing examples of where separation is working effectively, the differences within these systems and outcomes achieved for comprehensive industry-wide application would better inform this discussion.

Separation of standard setting and accrediting as a blanket requirement would be difficult to implement practically. Expertise related to standards being developed is required to ensure the development of professionally appropriate, evidenced based standards (eg the draft Radiology Standards, ACORN, laboratory standards through NATA).

The benefits of having a dual role allow for the use of accreditation data to inform standards development and focus training of surveyors. The paper notes a risk of potential conflict of interest by encouraging development of standards not integral to measuring safety or quality of standards compliance. There is little detail provided as examples of this and it is difficult to determine how separating these functions would reduce this risk as it may create a disconnection between standards and practical interpretation and application.

To some degree, the industry where selection of Accreditation provider is available provides a balance for this through either members changing providers or feedback through the standards development process. However, the cost of changing providers and resource impact of change limits the effectiveness of 'market forces'.

Enhancing options for representative stakeholder input would improve the standards development process. Recognition of industry changes (eg creation of large groups of hospitals, districts/regions) and ensuring mechanisms for meeting the needs of these new structures requires communication and engagement of the relevant stakeholders.

From a governance perspective, organizations (public or private) that have any role in setting standards, training surveyors or accrediting health services should ensure that there is equity in stakeholder input and representation where decisions are made that can affect a range of healthcare organizations.

### **4. Duplication and Overlap (page 16)**

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

An informed response on this issue is unable to be provided as analysis of what the differences are between programs and providers, and whether these warrant different sets of standards is lacking. With the scope of the review limited to Accreditation, it is difficult to identify how the impact of overlapping requirements can be analysed in depth. The detailed mapping of systems (as recommended) should inform this discussion and should be expanded to include state and national statutory bodies, health funds and other entities that require compliance with quality and safety standards.

It would be difficult to eliminate all separate accreditation processes as expertise is required (eg NATA accreditation, proposed accreditation of radiology services). Achievement of these specialised accreditation requirements should be recognized as achievement for all accreditation standards providers for any related standards.

The concerns noted regarding duplication are particularly relevant to Aged Care services, where there is potential for accreditation to be required under HACCC, Aged Care and ACHS Standards with variation in documentation and wording.

## **5. Resource requirements (pages 16-17)**

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

With the scope of the review limited to Accreditation, it is difficult to identify how the review will reduce the cost of compliance in the private sector as is not reflective of the standards burden. Reduction of the duplication from different entities eg Accreditation, licencing, Quality and Safety Agency, Health Fund would provide the most cost effective outcome for private providers. Extending the scope of the review to include analysis of the cost impost created by all quality and safety standards is recommended.

With reference to the examples provided - there is no doubt that the amount of documentation required to be completed prior to survey in the past has been resource intensive or that further review is warranted, however the full extent of the workload related to documentation is not necessarily as a result of the Accreditation agency's submission requirements. For example, for the last 4 years, ACHS have advised through industry communication and education sessions that the level of detail provided by some organizations was too process focused and excessive. The self assessment documentation has been substantially revised to address this. This problem highlights however the challenges to ensure industry-wide understanding of requirements and any change would require extensive education on requirements to be effective. The cost of this should be considered in the analysis of any change to the processes.

While acknowledging the need to ensure that standards require review to remain contemporary this should be done in a way that minimizes organizational impact. For example, the recent ACHS standards completely re-structured the standards, with almost every criteria and number altering after just a single cycle of the program (4 years). While no organization should develop systems around an Accreditation agency's requirements, many organizations structured their policies to the ACHS framework. As an example of one of the administrative impacts from the recent change – every policy referenced to the old standards is dated as soon the new standards are effective. Progressive change would be preferable to whole program change, however this would make organizational comparisons difficult.

Given the impact of change within an existing program, wholesale change of the Accreditation system would have significant resource and workload implications which would require substantial cost-benefit analysis before implementation.

## **6. Surveyors (pages 17-18)**

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

Consistent interpretation and application of standards and equity in consequences for all sectors of the health care industry is of significant concern. The challenge for the industry and the Accreditation agencies is how to manage this in a cost effective manner. Currently organizations pay an annual fee for membership, which is supplemented by many organizations through provision of senior staff as Surveyors. This helps manage the cost of membership as a completely professional Surveyor workforce would result in increased membership fees. With this in mind and assuming a cost-benefit analysis is available for analysis, the following actions could be explored:

✍ Improved education of surveyors to develop audit skills, understanding of the requirements of the standards, application in different sectors of the industry and the specific issues

being reviewed (credentialing requirements and application to the private sector vs. public sector). Regular update training should be a requirement for all surveyors.

✍ Guidance material should be developed for Surveyors and organizations and education to ensure interpretation of standards in a consistent and transparent way.

✍ Ensure surveyors have recent industry experience.

✍ Increase the number of 'professional' surveyors and monitor the quality of industry representatives to provide a balance between leadership within the industry and auditing skills.

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

In an industry where it is a challenge to employee experienced nurses, particularly for specialty areas such as ICU, midwifery and psychiatry– there is no easy answer to this. If staff are removed out of core services, scarce resources are being used to provide accreditation services.

Increasing the demand on surveyors will not only add costs but has potential to deter surveyors as would increase survey time and training time required to meet the standards set.

Based on current funding, the industry can not afford a totally professional surveyor workforce, which if introduced would require education processes to maintain contemporary understanding of healthcare related issues.

## **7. Information to support accreditation (pages 18-19)**

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

Agreed data sets that are risk adjusted as relevant to the services that are provided and with consideration that poor outcomes may be related to the pre-existing health status (eg obese patient, non-compliant patient)

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

Understanding of what accreditation data means in the general community  
Media education to support understanding of the system rather than using the data adversely.

## **Standards Issues (pages 20-22)**

### **1. Proliferation of Standards (pages 20-21)**

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

Proliferation of standards development should consider coordination of state and national legislation and bodies established for quality and safety as impact significantly on organizations with respect to this issue.

The government agencies (eg private licencing requirements, health legislators and bodies established for quality and safety) who currently have standards setting authority should be included in the review of standards.

## **2. Access to standards (page 21)**

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

Analysis of what and how much detail the community wants to know would be beneficial for responding to this question. It is debatable whether individual consumers would seek to review the actual standards an organization is accredited against before agreeing to have their procedure or seek confidence that regardless of which standards program is used the organization provides safe, quality care.

## **3. Process of developing standards (page 21)**

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

Proliferation of standards development and the need for streamlining this should consider coordination of state and national legislation and bodies established for quality and safety as impact significantly on organizations with respect to this issue. The compliance burden extends beyond Accreditation and improvements to effectiveness and efficiency would be limited if only Accreditation standards are reviewed.

## **4. Appropriateness of standards (page 22)**

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

Developing a single set of standards that is relevant and considered 'appropriate' by all health service providers (eg hospitals, practitioners) would be difficult to achieve due to the range and type of services provided within the industry. Analysis of the needs of different service providers, the existing compliance burden and the reasons behind the development of the existing standards would be required to assist this process.

A clear definition of what constitutes "appropriate" should be developed and agreed.

# **Accreditation Reform Strategies (pages 24-28)**

## **1. Register of accrediting bodies (page 24)**

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

The discussion implies much more than a 'register' in the form of having a single point of access for identifying and tracking accredited health services and accreditation bodies but rather the establishment of an entity that establishes standards required to be met for this process. While the discussion paper states that it is not proposed to be an expensive or bureaucratic process it is difficult to identify how this could be managed without the creation of an administration entity to establish the standards, monitor applications from Accreditation agencies, healthcare organizations and surveyors.

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

The discussion references accreditation bodies – however again misses the key issue of government developed standards such as private licencing, Health, Quality and Complaints Commission

## **2. Standardise accreditation language and definitions (page 25)**

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

Standards setting organizations and accreditation entities  
Proportionate representation from public and private sector

## **3. Training and competency testing of surveyors (page 25)**

This is one of the biggest issues with the current system – however change needs to consider the cost and resourcing impact. Demanding more services and a higher level of Surveyor performance will mean hospitals will pay more as members.

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

- Auditing skills and competency
- Objective application of standards
- Communication skills

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

- Resource considerations for any change must be analysed
- Industry-wide education, training and support

## **4. Better use of data for evaluation of health service performance (page 26)**

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

Available data sets should inform the setting and reviewing of standards in response to industry need to ensure these remain contemporary.

## **5. System wide accreditation against safety and quality standards (page 26)**

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

UnitingCare Health considers that all health providers and services should be required to comply with appropriate standards following consultation with relevant stakeholders. In practice, determining how specialists will achieve these without working together with the hospital providers for patients receiving in-patient care would be required and would require significant engagement of the industry with developing the standards. There should be mechanisms to engage Visiting Medical Practitioners in the quality systems of the hospitals they work at rather than as independent systems within their own practice.

State and national legislation and bodies establish quality and safety standards and establishing core standards should consider duplication and standardization by these bodies with respect to core safety and quality standards. The compliance burden extends beyond Accreditation and improvements to effectiveness and efficiency would be limited if only Accreditation standards are reviewed.

## **6. Introduction of unannounced surveys (page 27)**

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

A detailed analysis and stakeholder consultation process on how unannounced surveys would work, resource implications and whether this would create an additional review requirement for organizations would be required before introducing unannounced survey.

UnitingCare Health agrees with the premise that quality improvement should be a continuous process and that organizations should be open to scrutiny of care delivery systems at any time. Short notice/unannounced surveys already exist within Queensland, for example with the Private Licensing Unit, Workplace Health and Safety Queensland and other government agencies. These reviews tend to be issue specific rather than review of all corporate and clinical systems and limit the organizational impact as a result of this.

Should full assessments (as referenced) be implemented analysis of the resource impact for Surveyors and the organization would need to be undertaken. The current system for Accreditation with ACHS requires the submission of detailed documentation that allows for communication of organizational changes, issues and achievements to the surveyors prior to Accreditation. Acknowledging that this is resource intensive and options for reducing this should be explored, the documentation allows Surveyors to focus their review and gain some understanding of the key issues and challenges the organization has faced. Unannounced surveys would limit the value of this.

Giving notice also ensures that the relevant organization representatives are available to discuss systems implemented. While no system should be person dependent, having the responsible person available has some advantages.

If unannounced surveys are to be introduced, this must not create an extra burden in addition to current survey processes. While there may be value in assisting to improve quality systems with unannounced issue or service/system specific reviews this value is not as easily identifiable as it is for full surveys.

## **7. Introduction of Tracer Methodology in external accreditation reviews (page 28)**

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

It is difficult to answer the Commissions question in an informed way as there is little information available on how this would work in practice and little evidence supporting how effective this methodology has been in the US.

Questions that this raises are:

What is proposed as the outcome for the organisation being reviewed with this type of survey?

Would this be additional to unannounced surveys and organizational-wide surveys?

How would this work in private facilities where a range of independent providers such as pathology, radiology, visiting medical practitioners are involved in the provision of care? eg – if issues were identified with the radiology provider what would the outcome be for the hospital?

What would this methodology cost to implement – in terms of financial and human resources?

Where would the Surveyors come from and what skill base would be required to objectively apply the methodology?

## **Standards Reform Strategies (pages 29-31)**

### **1. Registrations of sets of health care standard (page 29)**

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

Refer to previous question re registration

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

Refer to previous question re registration

### **2. Harmonisation of health service standards (pages 29-30)**

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

More detailed analysis is required to respond in an informed way to this question. The range of services provided by the industry (aged care, mental health, day surgeries) may warrant some variation in language and definitions. Review of the variances and reasons for these would be beneficial.

Standardization would be beneficial for industry-wide comparison of performance regardless of Accreditation provider. This would also support informed choice by stakeholders in determining appropriate Accreditation providers.

- ✍ Who needs to be involved in this standardisation process?

Proportionate representation from all relevant stakeholders (Accreditation bodies, public and private hospitals, health service providers)

### **3. Detailed mapping of standards (page 30)**

- ✍ Who needs to be involved in this mapping process?

Proportionate representation from stakeholders (Accreditation bodies, public, private)

### **4. Identification of core safety and quality areas (page 30)**

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

Communication  
Infection Control  
Management of special needs patients – Aged/Obese

## **Mutual Recognition of Standards and Accreditation Processes (page 31)**

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

Analysis of programs, variances and reasons for these would be required to undertaken.  
Mapping of standards (Accreditation and other safety and quality standards will assist with this process.