



The Australian Council on Healthcare Standards

Submission to the
Australian Commission on Safety and Quality
in Health Care

in response to the

Discussion Paper:
*National Safety and Quality Accreditation
Standards (November 2006)*

30 March 2007

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Executive Summary

The Australian Council on Healthcare Standards (ACHS) is an independent not-for-profit organisation, with industry and consumer representation, dedicated to improving the safety and quality of health care. It is the leading national organisation for development of standards and performance assessment in the health industry.

The ACHS welcomes this review; with many of the issues covered having previously been proposed by the ACHS for broad discussion.

The ACHS is one of the most established and advanced health care accreditation organisations internationally. It is able to offer expert feedback, based in experience, to the Australian Commission on Safety and Quality in Health Care's *Discussion Paper – National Safety and Quality Accreditation Standards – November 2006*.

To inform the development of the ACHS response to the Discussion Paper, the ACHS undertook wide-ranging consultation with the Board, Council, consumer representatives, members, surveyors, employees and other key stakeholders.

The key messages from this response are:

- The ACHS supports a national approach to standards development and accreditation and identifies options for the establishment of a national governance structure.
- The ACHS recognises the considerable concerns across the industry as to the value and costs associated with creating further layers of governance and possible bureaucracy. A cost-efficient solution is advocated.
- The ACHS cautions the need for an effective governance framework to be determined before addressing the myriad of operational issues.
- The specific questions posed by the Commission in the Discussion Paper, under the headings of: Accreditation Issues, Standards Issues, and Future System and Processes are addressed.
- The ACHS pays particular attention to areas where the ACHS experience and consultation may offer insight into the proposals.
- The ACHS would also encourage more active involvement of consumers in development of proposals and believes the Discussion Paper would have been enhanced by a greater focus on consumer expectations.

As the Discussion Paper is presented from the context that a new accreditation model is required, a common theme throughout this response is encouragement to ensure proposals are explored in more detail and are research and evidence-based.

In 2005, through an Australian Research Council Linkage Grant, and in partnership with the University of NSW and industry partners, the ACHS commenced an examination of the relationship between accreditation and health care organisation performance. This is the first comprehensive research project of its kind, internationally, and the results will gradually be made available throughout 2007 and 2008.

Given the limited data currently available on the value of accreditation and the qualitative and anecdotal focus of some of the evidence in the Discussion Paper, the ACHS would encourage the results of this research being considered in developing a new national model for safety and quality accreditation standards and programs.

1. Introduction

The Australian Council on Healthcare Standards (ACHS) welcomes this review which it has promoted for some five years. The review is a positive step and will allow further development of many of the issues previously raised by the former Australian Council for Quality and Safety in Health Care in the publication *Standards settings and accreditation systems in health: Consultation paper, July 2003*. The ACHS has prepared its submission based on wide consultation with Board members, Councillors, consumer representatives, key stakeholders, member organisations, surveyors and employees.

The ACHS exists as an independent, not-for-profit company; it is effectively 'owned' by the health system. It has demonstrably and positively progressed attitudes and behaviour in respect of quality and safety across the Australian health industry since its inception in 1974.

The ACHS has a sound financial structure. Its programs have continually evolved to guide performance on a national basis. With over 1000 member organisations, its activities cover more than 90% of acute and subacute services and include the majority of both the public and private sectors. Members include hospitals, community health services, specialty services, membership based organisations and corporate bodies.

The main program offered, the Evaluation and Quality Improvement Program (EQuIP), was introduced in 1995 and changed the program's primary focus from organisational structures to one of patient and service outcomes. It embraces the concept that for any service to be optimal the entire organisation must function well. EQuIP is adaptable to virtually any setting or location. However, it can and does provide a basis for 'in depth' reviews of high priority areas, such as mental health and palliative care.

The ACHS prides itself on the consultative nature of its activities and the transparency of its governance and operational functions. Repeated surveys point to an above average level of satisfaction with its various activities. Its high national standing has provided the impetus, with Commonwealth Government support, in recent years to successfully market its expertise and programs into several international regions.

Its international reputation has seen it used as a source of advice and indeed a model for similar programs being developed elsewhere in the world.

The ACHS advocates accreditation being recognised as distinct from operational performance monitoring. For the purposes of this response to the *Australian Commission on Safety and Quality in Health Care's Discussion Paper – National Safety and Quality Accreditation Standards, November 2006*, the ACHS accepts the stated definition in the Discussion Paper that "accreditation is the granting of recognition for meeting designated standards for structure, process and outcomes, where outcome is the status of an individual, group of people or population which is wholly attributable to an action, agent or circumstance".

Internationally accreditation promotes overall safety and quality through continuous quality improvement. The results inform the assessment of operational performance, which is the responsibility of those who manage health care systems.

The tension between 'continuous quality improvement' and 'compliance' approaches has been a prevailing issue for many years. Research supports the view that whilst there is a place for regulation in a quality performance framework, the best gains are made by encouraging excellence through evidence-based continuous quality improvement. If accreditation is moved more towards a compliance model its value to the health industry and the community will be dissipated and may well be lost entirely. A compliance model can lead to confusion as to who is responsible for performance, particularly when serious service failures occur. Accreditation is one, albeit important, indicator of organisational performance. Accrediting (or performance assessing) organisations rarely, if ever, carry the obligation, right or capacity to make operational improvements. This is the responsibility of those persons with operational management accountability.

The Discussion Paper would have been enhanced by a greater focus on consumer expectations particularly as members of all survey teams. The ACHS experience points to consumers providing a different and insightful perspective of organisational performance.

In view of the significance of many of the matters proposed in the Discussion Paper the ACHS must express its concern that there is too much focus considered at a very operational level without adequate consideration of the needs of the industry and most importantly, health consumers at a higher level. Although it is mentioned briefly in the introduction that the Discussion Paper was to consider both the strengths and weaknesses of the current system the ACHS notes that there is very little consideration given within the Discussion Paper to the processes that are currently operating effectively.

It is of great concern that the paper relies heavily on anecdotal feedback from a limited sample of stakeholders and then suggests significant changes on the incorrect assumption that the feedback is representative of industry stakeholders. The ACHS cautions that there is a risk that the gains that have been made in safety and quality in health care may well be lost if such widespread changes are not given the appropriate level of cautious consideration by all relevant stakeholders before operational changes are implemented. This should be the foundation of a more substantial research program to inform the development of accreditation programs.

The ACHS believes that there is a critical need to address the governance requirements for implementation of many of the proposals suggested or implied. The development of an independent body to guide and inform these proposals would seem to be a critical factor that requires consideration before any actions are taken at an operational level.

The ACHS is supportive of a number of the concepts identified in the paper. There are, however, matters which the ACHS believes should be referred to an independent governing body at a national level for further assessment prior to implementation. All matters associated with standards and accreditation in health care should be protected from political influence at all levels and therefore the ACHS strongly recommends that consideration of the need to establish an independent national entity is an essential requirement before any reforms are implemented.

Consideration of a model for the structure of a standards and accreditation entity is included as a key issue. It seeks to address the proposals raised by the Commission as well as reflect the responses of the ACHS representatives consulted in preparing this submission.

The ACHS has also responded to the specific questions posed in the Australian Commission on Safety and Quality in Health Care's *Discussion Paper – National Safety and Quality Accreditation Standards, November 2006*. Responses to the questions reflect the views expressed in other areas of this submission.

With specific reference to the Commission's question around core standards, the ACHS believes it may be more practicable to suggest that at the national level the role of developing specific sets of standards would perhaps not be appropriate and that meeting the primary national safety needs would be best achieved through the development of core principles, which could be incorporated into standards through a standards registration process. Therefore when 'core standards' is discussed as part of the ACHS response it is from the position outlined above.

Comments on some aspects of the opinions contained within earlier parts of the Discussion Paper have been included as an attachment so as not to distract the focus from this very important project.

2. Suggested Model for National Governance of Standards and Accreditation

The ACHS supports the concept of a nationally coordinated approach to standards development and accreditation activities. The consequence of this is the inevitable creation of national system that will require a supporting governance structure. The costs of this must be minimised and the opportunity to do this exists by harnessing the enthusiasm and expertise of the current suppliers of these services.

However, a number of ACHS stakeholders have expressed concerns regarding the perceived need for an organisation which will essentially be "adding yet another layer of administration". The basis for that concern is at least three-fold, including that the proposal:

- will involve a further layer of bureaucracy;
- will increase costs; and
- may, inappropriately, be controlled by government as opposed to being truly independent as is the ideal situation.

As the Discussion Paper identifies, accreditation in health care in Australia is currently carried out by independent not-for-profit and for-profit bodies, as well as government not-for-profit agencies. If the proposal for an overarching accreditation entity proceeds, all categories of existing accreditation bodies should be subject to the new entity. Specifically, any processes to which independent accreditation bodies are to become subject should apply equally to government accreditation agencies.

In anticipation of a determination by the Australian Health Ministers' Conference on the advice of the Australian Commission on Safety and Quality in Health Care (the Commission) that an overarching national entity is required, the ACHS has contemplated a number of options for consideration by the Commission.

The ACHS is of the opinion that as a leading national organisation with considerable expertise in standards and accreditation in health care it would be well placed to manage a national entity established to undertake the considerations required. In addition, its commitment to research through a partnership with The University of New South Wales and involving other industry stakeholders would provide the foundation for the development of an important function for such an entity; currently an Australian Research Council Linkage Project into the value of accreditation is at an advanced stage.

Principles applicable to national standards and accreditation entity

If a decision is made to establish a national standards and accreditation entity, the ACHS proposes guiding principles for its establishment and operation be agreed. The ACHS proposes that the following list, which should not be regarded as exclusive, be considered as the fundamental principles essential to any proposed new accreditation entity:

1. the entity needs to be independent of government at all levels;
2. there must be appropriate representation by government without there being government control;
3. there must be appropriate mechanisms for stakeholder representation, with such representation to be reflected by appropriate membership of the Board;

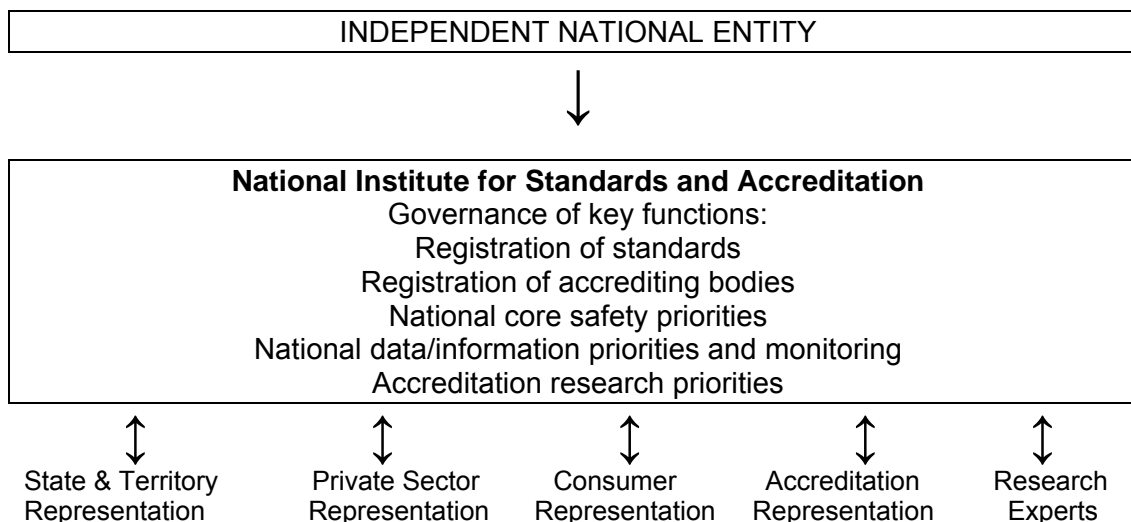
4. appropriate and objective criteria for assessment must be identified and agreed;
5. the new entity's functions should apply equally to government accreditation bodies as well as to private sector (whether for-profit or otherwise) accreditation bodies;
6. proper transitional arrangements, including an appropriate lead time, need to be put in place;
7. the workings of the entity should be transparent and consultative;
8. there needs to be an appropriate process for appeal against the entity's decisions; and
9. there needs to be appropriate resourcing.

2.1 Suggested Model

As noted in the consultation paper of the previous Australian Council for Safety and Quality in Health Care (“Standards Setting and Accreditation Systems in Health”, July 2003) there appear to be a number of issues for which a national approach to reforms in standards setting and accreditation processes would be most appropriate. Ideally the focus of the work of the national standards and accreditation entity would be on the strengthening of the processes that already exist (where those processes are acknowledged to be currently performing at a satisfactory level) and working to improve areas where consistency, comparability and other such improvements are suggested.

The ACHS has considered a range of possible governance structures and some of the key functions that would be appropriately managed by such a body. For the purposes of this discussion the ACHS proposes that the body be referred to as the National Institute for Standards and Accreditation in Healthcare (NIS&AH). The structure of the NIS&AH would need to be representative of the key stakeholders and inclusive of consumers.

Figure 1: Suggested Model for Structure of National Institute Standards and Accreditation



Composition Scope and Funding

The ACHS suggests that the NIS&AH must be representative of the key stakeholders that develop and use accreditation processes and standards in health care. At a minimum the ACHS has proposed that the following is required - representation from State and Territory health departments, private sector representation, consumer representation, representation from standards and accreditation bodies and research expertise.

Whilst the scope of the NIS&AH would need to be clearly articulated in terms of its functions, it would also be necessary to identify its governance structure. For example, if the NIS&AH proposed mandatory accreditation in health care it would be necessary that the services to which that would apply be clearly articulated. This would be best defined in the ‘terms of reference’ for the NIS&AH at the point of its establishment.

Funding of the NIS&AH would have to be sought and there would need to be some consideration given to the sustainability of the NIS&AH given the functions that are proposed. It is also important that the NIS&AH does not in anyway add an additional bureaucratic layer to what is well accepted to be an already complex process.

Consistent with the issues considered within the current Discussion Paper, it is suggested that the NIS&AH would have five core functions:

- **Standards:** registration, governance, consistency of language and accreditation requirements.
- **Accreditation:** registration, governance, surveyors training requirements and accreditation requirements.
- **Core standards for safety:** identification and monitoring.
- **Information:** national data priorities and monitoring.
- **Identification of research priorities** for standards and accreditation in health care.

Standards

The ACHS is supportive of a number of the proposals identified in the Discussion Paper regarding the reforms for standards setting in health care. It is acknowledged that there is a proliferation of standards and that the impact of standards within health care organisations needs to be better managed. A centralised process for managing (through registration) the number of organisations that develop standards will create an opportunity to ensure that these bodies encompass sound processes for developing standards. For example: appropriate governance of the process, appropriate stakeholder and consumer consultation and transparency of process.

It is also recommended that the requirements for being registered as a standards setting body includes the organisation having an appropriate third party accreditation system in place as well as conformity to the guidelines and definitional requirements of the NIS&AH. A centralised process of registration would also be a way in which duplication of standards could be managed by ensuring that there is a process for cross-referencing to existing standards that have been previously registered.

Accreditation Systems

The NIS&AH should manage the type and number of organisations that are able to accredit facilities against a 'registered' set of standards. As part of the registration process, it is proposed that the NIS&AH could impose approved principles for the governance of the accreditation process, third party accreditation requirements of accreditation organisations as well as the requirements for the training needs of surveyors. Organisations seeking to become registered accrediting organisations would have to apply on the basis of meeting, or committing to meet, the requirements as stated by the NIS&AH.

The current Discussion Paper states that not all organisations in Australia serve the dual purpose of developing standards and accrediting against those standards before going on to suggest that the dual role may create a conflict of interest. It is not the view of the ACHS that the mutual exclusion of both functions necessarily improves the accreditation process and the ACHS would assert there are distinct benefits in aligning both functions. It is not a question of alleged conflicts of interest, but rather one of the process followed in both developing and reviewing standards. However, the proposed model could assure that the risk of the suggested conflict of interest was managed by requiring each function be registered separately even if they are performed by the same organisation.

Core Standards for Safety

It is noted that there is a definitive position described in the Discussion Paper that suggests that there needs to be identification of core safety and quality areas that are to be reflected in all registered sets of safety and quality standards for health care. Although there would need to be considerable consultation to reach agreement between all sectors, health services, states and territories on the process for selecting the priority for core areas for health care it is also a process that the ACHS believes would fit well within the suggested model of the NIS&AH.

There would be good alignment between this function and the process for registering standards if both processes operated within the NIS&AH. There could also be a strong link with research into defining the priority areas for the development of core standards. It is however more practicable to suggest that at the national level the role of developing specific sets of standards would perhaps not be appropriate and that meeting the primary national safety needs would be best achieved through the development of core principles, which the NIS&AH could ensure were incorporated into standards through the standards registration process. It is not clear to the ACHS that one set of core standards for safety could be developed that would be applicable to all circumstances. This would be a worthwhile topic for further exploration. The advantage of establishing core principles for safety is that the responsibility would then vest in the organisations developing standards to demonstrably incorporate them into standards developed for specific application.

Information Priorities

The ACHS supports the need for considerable development in the process to identify and implement some key national priorities for the collation of accreditation data. The ACHS currently reports performance against its accreditation standards in the *ACHS National Report on Health Services Accreditation Performance*, which is due to have a second edition published in August 2007 (reporting on 2005 and 2006). The ACHS is also very supportive of the current efforts of the Australian Commission on Safety and Quality in Health Care in its focus on a national approach to information collection. The ACHS is of the opinion that many improvement opportunities related to data analysis at a national level are lost (in part) due to individual jurisdictional inconsistencies and requirements.

The ACHS believes that a national body such as the NIS&AH would be well placed to progress the work that has already commenced to ensure that there is a national approach to the collection of accreditation information. The ACHS believes it is very important that the governance of this process is independent and hence proposes that a structure such as the one suggested in this submission would be ideal in meeting that requirement. The ACHS believes that national priorities for information management related to standards and accreditation are well aligned with the proposed research and core standards functions in the suggested model of the NIS&AH.

Research Priorities

After giving careful consideration to the importance of ensuring good governance for the role of the suggested NIS&AH it is recommended that any significant changes to the future of standards setting and accreditation in health care are based upon the appropriate level of research. The NIS&AH would be able to set the priority areas for researching aspects of standards setting and accreditation such as the proposed surveying methods of Tracer Methodology and unannounced surveys.

Given the impact that significant change to current process can have on what are already very limited resources in health care the ACHS feels strongly that such proposed changes need to be appropriately researched prior to implementation. The role of the NIS&AH would be firstly to identify the research priorities and then to partner with appropriate organisations to undertake the necessary research activities.

2.2 Options for entity to ensure independent national accountability

The ACHS suggests that there is a wide range of options available to ensure independent national accountability for the NIS&AH. They include, using or modifying an existing or proposed statutory body, utilising existing standards organisations or establishing a new entity either by legislation or as a public company. The ACHS has considered a number of options in detail to highlight the scope of the existing possibilities, rather than recommending a particular entity.

1. National Health and Medical Research Council

The National Health and Medical Research Council (**NHMRC**) was originally established as the Federal Health Council following recommendations made by a Royal Commission in 1986. It was established as a national organisation by the *National Health and Medical Research Council Act 1992 (Cth)* (the **NHMRC Act**). According to the NHMRC's 2005 annual report, from 1 July 2006 the NHMRC became a fully independent statutory agency falling within the Health and Ageing portfolio. The NHMRC and the Department of Health and Ageing entered into a memorandum of understanding and service level agreement as part of this transition. Section 7 of the NHMRC Act outlines the functions of the NHMRC. These essentially involve:

- (a) inquiring into health and health care, disease prevention, research and related ethical issues;
- (b) making recommendations to the Commonwealth on related expenditure;
- (c) issuing guidelines; and
- (d) advising community and governmental authorities.

The NHMRC also has various functions under the *Research Involving Human Embryos Act 2002 (Cth)*, the *Prohibition of Human Cloning Act 2002 (Cth)* and corresponding State and Territory legislation.

The organisational structure of the NHMRC includes the NHMRC Council and CEO, as well as a number of expert committees and working committees. The principal Committees currently include:

- (a) National Health Committee (**NHC**) (which manages and coordinates development of advice and guidelines on all health issues);
- (b) Human Genetics Advisory Committee (which advises government on high-level technical and strategic issues in human genetics and social, ethical and legal implications);
- (c) Research Committee (which advises the NHMRC on medical research and public health research, including quality and scope of research in Australia)

- (d) Licensing Committee (which oversees national regulatory framework on embryo research under the *Research Involving Human Embryos Act 2002* (Cth) and the *Prohibition of Human Cloning Act 2002* (Cth));
- (e) Australian Health Ethics Committee (which advises the NHMRC on ethical issues relating to health and developing guidelines on medical research involving humans); and
- (f) Aboriginal and Torres Strait Islander Health Forum.

Discussion

The NHMRC already includes an established National Health Committee (NHC) which has as one of its functions the production of evidence-based guidelines regarding, amongst other things, health systems, service delivery and the safety and quality of care. New legislation would most likely not be required but resourcing, financial and workforce issues would need to be addressed if the NHC of the NHMRC was to take on extra functions. State and Territory government cooperation would also be required.

Although the NHMRC's status as a fully independent statutory agency provides an assurance of some degree of independence, the nature of representation at the Council level, which is presently skewed towards doctors, academics and researchers, would need consideration, as would membership of the National Health Committee itself.

2. Australian Institute of Health and Welfare

The Australian Institute of Health and Welfare (**Institute**) was established by the *Australian Institute of Health and Welfare Act 1987* (Cth) (the **AIHW Act**). The Institute is defined as a body corporate subject to the *Commonwealth Authorities and Companies Act 1997* (Cth).

The Institute is a Federal government statutory agency. As part of the Health and Ageing portfolio, it reports directly to the Minister for Health and Ageing and through the Minister to Parliament.

The Institute's main functions are outlined in S.5 of the AIHW Act. They involve collecting, analysing and disseminating health and welfare-related information and statistics. The Institute provides information and analysis to the Commonwealth, State and Territory governments, as well as to non-government clients, relating to health, community services and housing assistance. The Institute aims to release most information into the public domain.

Discussion

Use of this option for accreditation would most likely require amending legislation, as well as representation of stakeholders and appropriate resourcing.

3. Proposed national registration body for health professionals

There has recently been discussion around establishment of a national registration body for health professionals. This proposal has been recently advanced by the Prime Minister and has the support of some State governments.

Discussion

No such national registration body currently exists, and in practice it may not be brought into existence in the near future or at all. We note at least one report that the Australian Medical Association opposes the proposal.

The use for accreditation purposes of the proposed body (if it proceeds) would need to be preceded by extensive consultation with both the stakeholder professional bodies and the State and Territory governments, each of whose cooperation would be required for the proposal to proceed and be effective. Legislation would need to be introduced to affect it. However, arguably the purpose of standard setting may be regarded as analogous to the proposed national role.

4. Private Health Insurance Administration Council

The Private Health Insurance Administration Council (**PHIAC**) was established as a body corporate under Part VIAA of the *National Health Act 1953* (Cth) (the **NHA Act**). PHIAC is an independent statutory authority that regulates the private health insurance industry. PHIAC also collects and disseminates financial and statistical data regarding health funds and information about private health insurance to enable consumers to make informed choices about private health insurance. Section 82G of the NHA Act sets out 29 functions of PHIAC. These functions provide that it does have a role in setting standards relating to financial information, but no equivalent role in relation to clinical or operational standards.

Discussion

Private health insurance is central to the functions of PHIAC. Funding is integral to performance and therefore there is a potential logical connection with accreditation. We also note that the *Private Health Insurance Bill 2007* proposes that there will be safety and quality responsibilities imposed on health service providers in order for them to receive benefits from health insurers.

Whilst PHIAC concerns itself with the private health insurance industry, because private patients are also treated in public sector facilities, in practice PHIAC's regulatory role covers both groups and the health sector generally through private health insurance insofar as it applies to, for example, dentistry, physiotherapy, optometry, podiatry etc..

Amendment to legislation would be required in order to appropriately broaden PHIAC's powers and functions.

5. A new company limited by guarantee

A further option is to set up a special purpose entity as a company limited by guarantee.

A company limited by guarantee is a public company. Unlike normal trading companies (such as proprietary company limited by shares), a company limited by guarantee does not have shareholders or share capital. Instead, each member of the company will agree to contribute a certain amount in the event that the company is wound up. The amount of the guarantee is specified in the constitution. This corporate structure is most often used where profit is not the prime objective of the enterprise.

Other matters such as admission to membership, voting rights, participation in and termination of membership, may be provided for by the provisions of the Corporations Act that apply to the company as "replaceable rules" (s 134), by a

constitution, or a combination of both. That is, a company's constitution can displace or modify the "replaceable rules" contained in the Corporations Act which automatically apply to all companies. The ACHS view is that a specific constitution would be required.

Public companies have some requirements which limit the flexibility of their internal management structure. For example, public companies are required to appoint at least three directors (s 201A) and a minimum number of members.

Discussion

Issues for consideration include the choice of members, the election of board members and the need to provide for a level of independence so as to ensure that the entity is immune from inappropriate interference from stakeholders.

6. A specific standards organisation

There is already a number of existing standards organisations such as the ACHS which could take on an overarching accrediting role.

Discussion

There may be resistance to this model because of competition between existing organisations as to which is best placed to perform the work and any perceived advantage that that may provide. Other issues for consideration include the need for stakeholder buy-in, the nature and extent of the organisation's charter, and the appointment of an appropriately constituted board.

The ACHS was one of the first accreditation bodies in Australia and has been a pre-eminent participant in this regard for several decades. As such, the view may be formed that the activities of the proposed new entity could be carried out by, or under the auspices of, the ACHS, for example by creation of a separate company or a division of the ACHS, contingent upon appropriate membership and resourcing.

7. Establishment of a specific entity by legislation

Each of the previous options, with the exception of the proposal for creation of a special purpose company limited by guarantee, involve to a greater or lesser degree the adaptation of an existing body to fulfil the role of the new accreditation entity.

Discussion

Whilst it would be time consuming and would involve extensive consultation, a further option is to create a new body with a single specific purpose. The advantage of this option is that the entity could be created *de novo* without the distraction of prior functions, loyalties and commitments. The extent of consultation required to ensure the cooperation of stakeholders, including State and Territory governments, would mean this would be a proposition with a medium lead time before implementation. However, it is most likely to be the model that creates the least burden in terms of bureaucracy and cost.

3. Responses to specific questions raised in the Discussion Paper

The following responses are to the specific questions raised in the Commission's Discussion Paper. They are set out in the order they appear in that document and use the same numbering sequence.

6. ACCREDITATION ISSUES

1. Effectiveness in identifying poor performance

Commission questions:

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

Where there is a systems failure, should the accreditation body be responsible for taking action to inform the public, government, corporate owner and/or health insurers?

Comment

The opportunity to identify poor performance should exist in an organisation through a networked process of management systems, constructed to monitor performance and prevent/minimise adverse incidents. An organisation's risk management and quality improvement program (including accreditation) should have this as its objective. The ACHS accreditation program is deliberately structured to consider the whole organisation's performance, given the complex nature of care delivery systems. It is designed to be a quality framework for adaptation by each member organisation, which must determine how best to apply it in the local circumstances. If comprehensively implemented it minimises risk. It is unrealistic to ever expect that accreditation, in isolation, is an assurance of a completely risk-free environment.

Accreditation focuses on a review of systems and does not guarantee that service failures will not occur. However, research does support the position that most adverse events/near misses arise from system failures. By focusing on systems accreditation processes have an important role in minimising organisational risk.

The Discussion Paper suggests that in Australia the process of accreditation has been criticised for "not reliably detecting poor performance" and it also notes that critics of the survey process suggest that accreditation processes are not effective at identifying patient outcomes. The ACHS considers this view to be simplistic and ill-informed. Accrediting organisations do not have operational management responsibility and can therefore never accept to be solely responsible for identifying poor performance or assuring a "one stop guarantee" of patient safety. The ACHS program does indeed focus on patient outcomes and the ACHS would dispute strongly the inference made that accreditation programs are of limited value in identifying under-performance.

If a systems failure is noted through the accreditation process then the accrediting body must have a transparent and consistent method for assessing and addressing the matter. If the matter is deemed to be of great significance then the management of the organisation must be immediately informed. Processes must also exist to ensure that the matter is addressed by the management to rectify the failure and minimise or eliminate the risk of the failure recurring. Informing the public of service failure is appropriate, but what is more important is the action taken by a health care

organisation to improve performance. Therefore, the timing of the release of such information is a topic that needs separate consideration.

The ACHS Response

1. Accreditation programs (standards and performance assessment) are only part of a more comprehensive package that must include internal performance monitoring systems that involve data collection.
2. Accreditation programs provide a framework for quality that monitors internal performance in an organisation as well as providing guidance on its implementation, but that ultimately responsibility for implementation and therefore detecting poor performance is a service management function.
3. In the event that the monitoring system is found to be deficient the ACHS directs its concerns immediately to the health care organisation's management and possibly the owner (be that a government body or corporate owner), preferably in cooperation with the person responsible for managing that service. Notification beyond that reference should be the responsibility of corporate owners; therefore it would not automatically include other third party funders, for example health insurers. Contractual arrangements to facilitate such a process would need to be put in place, ideally in conjunction with national guidance on appropriate notification.

2. Transparency

Commission questions:

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

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

Comment

It is suggested in the Commission's Discussion Paper that there are three points of transparency – transparency of decision making processes, transparency related to reporting on the outcome of the accreditation process and transparency through public access to accreditation information. There is no reference to the fact that there is not a consistent method of responding to organisations that pose an unacceptable safety and quality risk nor is there a consistent method for the appropriate management of the results of assessment. It is further stated in the Discussion Paper that owners (i.e. State health departments and private hospital owners) need to comment on draft survey reports and then implement accreditation recommendations as they are the authority that can implement recommendations and make improvements. Whilst this is important, caution needs to be taken to ensure that the independence of the accreditation body is not in any way compromised through this process. The ACHS draft reports are provided for the correction of any errors of fact. It is critical to the credibility of the accreditation process that the independence of the accrediting body is not perceived to be open to the influence (be that perceived or otherwise) of the owner organisations.

In exploring the issue of increasing pressure from consumers for health services to disclose details concerning good and poor quality service, it is suggested that unlike aged care reports on accreditation there is currently only information regarding accreditation status and agreed statements on accreditation outcomes publicly available. The ACHS has recently determined that agreed performance statements following completion of a survey report must be published, for all surveys commencing from 1 July 2007, and current contracts are being revised to support

this initiative. Consultation is being undertaken as to the extent of material that should be published and the administrative systems required.

The ACHS Response

1. The importance of accreditation processes being conducted independently of the jurisdictional and operational systems is a critical dimension in ensuring transparency and thereby stakeholder confidence in a program.
2. The absence of a profit motive in the ACHS business structure is also regarded as being of fundamental importance as it counters perceptions of commercial considerations dominating decision making and administrative processes.
3. The ACHS program, encapsulating a clear decision making process as to an organisation's accreditation status and publication of performance information, includes key components of an open and transparent system. In addition, the operating rules that explain how the program is administered are shortly to be available on the website. This range of information should be required of all programs.
4. The ACHS supports a position where the onus to seek owner input on draft survey reports should rest with the organisation that has been reviewed. This is not to say that owners should not receive copies of draft reports, but rather that the ACHS should relate exclusively to the organisation being assessed. The ACHS is prepared to support copies of such communications being sent simultaneously to the owner if required. To introduce another level of required consultation would add to the ACHS' administrative costs and potentially compromise the independence of the ACHS.
5. The minimum level of information released publicly to meet the expectations of consumers and the facility would include a broad statement of performance that drew attention to both the identified strengths and weaknesses. The next level of information that should be considered for publication would include performance summaries for key sections of the report and an organisational response, particularly in relation to improvement steps being taken. The foregoing statements should be drafted in plain English. Ideally, these statements should facilitate access to the entire survey report, at the discretion of a reader.

3. Governance

Commission question:

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

Comment

The Commission notes that some (not all) bodies that set standards also accredit against those standards and suggests that the dual role may pose a risk of conflict of interest such as developing standards not integral to measuring safety and quality. The example of health funders is used to highlight the point that there needs to be an external and independent assessment process.

The comments in this section of the Discussion Paper are selective and not accurate. Other Australian organisations both setting standards and conducting accreditation programs include the Quality Improvement Council and it can be argued that given the commercial relationship between Standards Australia and SAI Global that they represent a single entity. In addition, the pathology laboratory accreditation program is oversighted by The National Pathology Accreditation Advisory Council, which includes the performance assessing body, NATA. The proposed accreditation

program for medical imaging services is being steered by a group that are parties to a memorandum of understanding covering this service activity and that group involves both the College (standards setting) and NATA (accrediting).

Internationally, other major countries where both activities are combined include the Republic of Ireland, Denmark, France and now India.

There are significant benefits to be gained by having performance assessment expertise intimately involved in the process of developing and reviewing standards. Therefore the ACHS argues that what is important is the process that is followed not arbitrary separation; the 'how' rather than the 'who'. Separation would also be expected to increase administrative costs.

There is substantial international recognition that organisations involved in either or both activities should be accredited (as an organisation and through sets of standards) through an internationally recognised process, such as that provided by the International Society for Quality in Health Care (ISQua) or ISO. This should form part of an organisation's accountability framework to stakeholders.

The ACHS Response

1. The preferred principles for good governance for accreditation related organisations should include:
 - An altruistic commitment to quality and safety
 - Transparency of processes
 - Not-for-profit
 - Independence
 - Consultative approach
 - Accountability
2. In the interests of good governance all accrediting organisations should be themselves externally and independently evaluated/accredited (as is the ACHS through the International Society for Quality in Health Care - ISQua).
3. The ACHS supports the position that good governance requires the separate accreditation of key functions, including standards, accrediting organisations and surveyor training programs.
4. The ACHS argues that rather than be concerned with the separation of standards setting and accrediting what is important is the process that is followed not their arbitrary separation; the 'how' rather than the 'who'.
5. A rigorous process for standards setting must include:
 - A recognised need
 - An available evidence base (for at least the majority of standards)
 - An outcome focus
 - A whole of organisation perspective
 - Achievability
 - Measurability
 - Consultation (particularly in respect of national priorities and stakeholders)
 - Transparency

4. Duplication and overlap

Commission question:

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

Comment

The comment arising from the Patterson Report is made that organisations having to undergo repeated accreditation surveys by different organisations is not ideal, when an organisation-wide approach would be more efficient and appropriate to reduce additional cost and time burdens. This position is strongly supported by the ACHS which has provided the leading organisational-wide program for over three decades. In supporting the need in some instances for specialised service standards, the ACHS is concerned to ensure that the proliferation of service focussed standards does not in any way compromise the whole of organisation approach which is critical to the provision of safety.

The Discussion Paper suggests that a national agreement on a mechanism to recognise the accreditation processes or standards of another organisation is required in order that accreditation programs can become mutually supportive and integrated.

The following response needs to be read in concert with the ACHS responses in other sections of this paper.

The ACHS Response

1. The ACHS supports the minimisation of the number of recognised standard setting and/or accrediting organisations.
2. Standards should be nationally recognised by an appropriate body established to oversight this activity and grant 'recognition of need' where appropriate.
3. The establishment of core standards, mainly focused on governance and patient safety, should be identified and their incorporation into all sets of standards required.
4. Standards should be grouped into two clusters comprising 'generic or significant topic areas', and 'service specific areas'. The second grouping should be the subject of 'in-depth assessments' conducted as part of a generic program. In-depth reviews could be conducted concurrent with generic reviews or following their completion. Examples of 'generic or significant topic areas' could include EQulP 4, Pathology Laboratories (an existing nationally significant program) whilst 'service specific' standards could include National Mental Health Services, palliative care, Home and Community Care and post-graduate medical training.
5. Mechanisms should be put in place to facilitate the sharing of survey information and to allow its application in meeting multiple performance assessment requirements. There would be contractual and information security issues to be addressed.
6. The major recognised standards setting/accrediting organisations together with other stakeholders should undertake the development and trialling of integrated surveys, to evaluate there efficacy and cost comparisons. This project should identify and evaluate long-term options for a sustainable model of integration.

5. Resource requirements

Commission question:

How can accreditation be made more cost efficient and effective?

Comment

It is asserted that there has been an increase in the number and scope of accreditation processes for Australian health services. It is also stated that the cost of investment in accreditation is disproportional to the gains that are achieved in safety

and quality as a result and that the current proliferation of standards and programs only adds to those concerns.

Standards have an enormous potential to guide and support good practice as well as to provide a focus on priority areas/issues, but if there are too many sets or programs are too numerous their potential impact is lost. Each set of standards brings its own costs.

There are grounds for a reassessment of current performance assessment strategies, particularly with the increasing availability of electronic information systems that can support data capture, analysis and information transfer. However, a greater reliance on data presumes consistency in nationally available information systems, which is not the present situation. The work being undertaken by the Commission in relation to safety and quality information systems will be central to developing a solution.

One inference of this question is that quality still seems to be regarded as an added task in managing many health services rather than a key management responsibility as is the case in financial management and productivity environments.

The ACHS Response

1. In 2006 the ACHS commenced looking at future options for surveying strategies, influenced by concerns relating to surveyor availability, cost pressures, discussions with members, mainly arising from their concerns with the growing number of sets of standards and an awareness that improved access to data may facilitate an alternative and more cost efficient approach. There is a strong view amongst our member organisations and other stakeholders that organisation-wide surveys are valuable. However, a significant number of people have expressed the view that interim surveys (periodic reviews) would be more valued if they were focused on specific activities, as well as reviewing progress since the previous report. This and other alternative approaches should be trialled with a view to developing a more integrated and targeted framework that encompasses priority assessment activities.
2. The ACHS advocates the position that the integrity and intent of the accreditation process could be maintained if the process became more reliant on reported data combined with fewer/smaller surveys.
3. The ACHS would, in principle, support an arrangement requiring the sharing of its data and survey information with other agencies involved in an integrated and not-for-profit alignment of activities.

6. Surveyors

Commission questions:

What must be done to ensure inter-surveyor reliability?

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

Comment

Accreditation agencies continue to work to increase consistency within the surveyor workforce. The assertion that if the current number of accreditation systems continues to grow then the resultant impact on the limited (primarily voluntary) pool of surveyors is unsustainable is supported.

The design and structure of standards is, from our experience, pivotal to maximising inter-rater reliability as is the consistent use of language and definitions. The 'layering of information' contained within the EQulP framework (standards, criteria, elements and guidelines) has greatly improved results in this area. However, several other points need to be recognised as important in contributing to improving inter-surveyor reliability:

- The appointment of coordinators with advanced training to lead survey teams;
- The employment of surveyors, which is commented on further below; and
- The program for selection, training, performance management and ongoing development of surveyors.

The Discussion Paper's comment that the employment of surveyors is a likely option that may occur as the health workforce shortages lessen the availability of voluntary surveyors is noted. The ACHS introduced full-time paid surveyors two years ago, initially on a trial basis. It has proven very successful and will be retained. Importantly, the surveyors were drawn from the health industry and had substantial experience in both management and clinical care.

Jurisdictions and private owners should be strongly encouraged to support appropriate staff (particularly emerging leaders) to be surveyors on either a part-time or full-time basis for an appropriate period of time. The opportunities exist to make gains in practical skills and knowledge sharing for organisations as well as professional development for individuals.

The ACHS has obtained endorsement from a wide range of professional colleges for recognition of time spent on surveying activities to fulfil their continuing professional development requirements.

The ACHS Response

1. There should be a robust and comprehensive selection, training, ongoing development and performance monitoring program for surveyors, which is integral to the provision of a high quality accreditation program.
2. The format for sets of standards and consistency in the use of language would minimise the possible adverse impacts of variations in the observation of surveyors (commonly referred to as 'inter-rater reliability').
3. The role of leading survey teams should be recognised as requiring different but integral skills to surveying and consideration should be given to requiring accrediting organisations to include this component in appropriate training and development programs.
4. Public and private sectors as well as professional organisations and professional colleges should be asked to demonstrably support surveying as a valued professional activity. In particular, consideration should be given to seeking support from both public and private funders of health services.

7. Information to support accreditation

Commission questions:

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

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

Comment

The Discussion Paper states that publicly available information on accredited health services is currently limited. It notes that the ACHS makes some information available, but it is suggested that this information is not to the level that is required by the public and that it is limited by the fact that the national data the ACHS has is not used optimally to determine existing or emerging safety and quality trends because the collection and reporting of the data is a voluntary process.

The Commission's current work in this area is of key importance, as noted earlier. There is a brief reference made to the fact that the National Health Information Group could generate national health statistics if they were to include the use of accreditation data.

The apparent strong preference of the Commission for the public release of accreditation information and data is supported, notwithstanding it also cautions that accreditation information may be misinterpreted and the potential for inaccurate reporting may be problematic. The ACHS suggests that perhaps the Australian Commission on Safety and Quality in Health Care could take a national leadership role in educating both the media and the public about the appropriate interpretation and use of such information, which would be actively supported by the ACHS.

The ACHS Response

1. In principle the ACHS would agree with identified accreditation and related data for each member organisation being made available to the Australian Commission on Safety and Quality in Health Care or other like body. However, there would need to be industry-wide support for this to occur and appropriate administrative arrangements put in place.
2. The ACHS believes it would be essential to have assurances in place to guard against its misuse or risk of misinterpretation.
3. Data to be collected for analyses at a national level must be standardised to ensure valid comparison.

7. STANDARDS ISSUES

1. Proliferation of Standards

Commission question:

What initiatives are required to coordinate and harmonise standards?

As suggested in the Discussion Paper, in Australia there are no external barriers to developing standards nor is there any consistency in organisations assessing the impact of implementation such as ensuring that the necessary infrastructure and funding are available. The significant resources required for the development and review of standards is acknowledged. In reviewing the current situation there may be advantages in concentrating the technical skills required for the development of standards in fewer entities. Expert input would be available from within the industry via consultation.

The inference made in the Discussion Paper, that the considerable investment in standards development is not warranted on the basis that there is no direct evidence that standards improve quality and safety for patients, is not accepted by the ACHS. Rather the ACHS asserts that what has been lacking until the recent past is the lack of any commitment to research this and related topics. The ACHS is now actively involved in an academic program of research. Therefore the ACHS would have preferred that the issue had been couched in terms of identifying the need for research to better understand the nexus. One outcome of such a research program should be to better inform the decision making process as to whether standards should be developed in a particular area on a more reliable and consistent basis.

It is agreed that standards should be more consistent and coordinated in their language, structure and scope in order to reduce the complexity of accreditation processes and the burden of compliance requirements for health services. It would facilitate a more integrated accrediting program, which could include sharing of information, common core standards and simultaneous/sequential assessment of organisations across several sets of standards.

The ACHS believes there is substantial support for such an approach among relevant bodies, but it requires high level endorsement and resources to advance an agenda.

The following responses need to also be read in the context of earlier remarks in this submission.

The ACHS Response

1. A nationally convened group, with an appropriate line of accountability, be established with the following functions:
 - Standardisation of language and definitions
 - Recognising the need for standards in a particular area
 - Recognising standards for use once development is completed
 - Maintenance of a register of standards in a publicly accessible form
2. The development of standards within an agreed framework that guides the process for their development. Standards should be subject to an external and internationally-recognised process of validation against that framework.

2. Access to Standards

Commission question:

What minimum information should be publicly available on accreditation standards?

Comment

The Commission notes that for some standards setting bodies in Australia, the sale of standards is a major revenue source and acknowledges that any suggestion to make standards publicly available is likely to be met with resistance. It is also noted that both Australian and international reviews have recommended that low cost access to standards should be provided to the public. The ACHS argues that standards should be available free of cost. They define minimum standards for safety and quality across industries, underpin business confidence in a particular product or area and are informative for a wide range of consumers. Access to such fundamentally important information should not be restricted by a fee.

The ACHS has long moved away from selling standards as a major component of its revenue stream. Rather the ACHS sells membership of a very successful and long standing industry based program, which includes membership support, quality improvement review and recommendations, electronic tools, printed and web-based resources, the clinical indicator service, onsite surveys etc. ACHS standards are available on the publicly accessible section of our website:

<http://www.achs.org.au/EQUIP4/>

http://www.achs.org.au/pdf/E4A3_poster.mandcriteria.pdf

The ACHS Response

1. Accreditation standards and criteria should be available free of charge. The ACHS believes that this is an important factor in ensuring transparency of the accreditation process.

3. Process of developing standards

Commission question:

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

Comment

It is noted that both ISQua and ISO have guidelines for the development of standards and that the organisations associated with these bodies develop standards in accordance with the respective guidelines. The ACHS supports the position that all standards setting bodies should do so using a “best practice” model. It also supports the need for consistency in the language and definitions used.

This is a complex issue as jurisdictions and other major funders should have significant input into the nature of standards at a strategic level. However, there needs to be a very clear separation between the standards setting body and those that fund health care organisations in order that the independence of the standards is not compromised. The ACHS believes this can be managed by consultation and governance requirements imposed through the ‘registration of standards’ process at a national level.

The ACHS Response

1. In its standards development processes the ACHS conforms to the principles of ISQua and the proposed principles stated in the Productivity Commission Review on Standards Setting and Laboratory Accreditation. All standards development should be required to conform to an internationally recognised process.
2. A standardised approach to the use of language and definitions for quality in health care is supported.
3. The authority to develop standards should be vested in a small number of independent organisations, such as the ACHS, which have the relevant expertise.

4. Appropriateness of standards

Commission question:

How do you ensure that the standards being assessed are appropriate?

Comment

Reference is made specifically to the ACHS in the context of questioning whether a single set of standards can be applied to a broad range of health services. The generic nature of the industry-based ACHS program and its flexibility in being applied in different settings is one of its great strengths which is well supported by the organisations that use the standards. The consistency of performance requirements also has great benefit in building information sets across the industry that provides the basis for very valuable comparative analyses.

The Commission would recognise that the knowledge and technical revolution that has taken place over recent decades now supports quite complex services being provided in a non-institutional setting. However, the patient safety considerations in these alternative settings should not result in a lowering of quality and safety expectations.

The ACHS is not aware of any evidence to support the assertion in respect to ISO that more “health services are being certified against these standards”. There are a number of organisations who provide ISO certification services and some of these provide services to the health industry. Whilst having alternative sets of standards and/or assessment processes may be regarded as necessary for the benefit of competition in the market place, the ACHS regards this as a false debate as the real issue is one of ‘public benefit’. Alternative sets of standards and/or assessment processes should not exist if the level of requirements in the standards and/or assessment processes is inconsistent. The community and jurisdictions would rightly have an expectation that there is consistency in the provision of accreditation.

Comments have been made elsewhere in this response as to the nature of the ACHS approach in developing standards. It has gained substantial international standing and has been used to guide the development of similar programs in other countries. This approach involves very substantial consultation.

The ACHS Response

1. For the reasons expressed previously the ACHS believes there is an important need for a generic set of industry specific standards, such as EQulP for general application.
2. This can and should be complemented by other generic sets as previously referred to, but can also be able to support other service specific sets of standards.

8. FUTURE SYSTEMS AND PROCESSES

8.1 Accreditation Reform Strategies

1. Register of accrediting bodies

Commission questions:

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

Which organisation is best placed to manage the registration of accreditation bodies?

Comment

The proposal for the mandatory registration of health care accreditation organisations is a positive step in monitoring and controlling the number of accreditation schemes. The register should be publicly accessible. It would be an important step towards the data collected being applied to a number of analytical processes in relation to the safety and quality of the health system. This would be facilitated by the identification of fundamental standards for safety that are common to all programs as expressed by the ACHS earlier in this submission.

The proposal for the body maintaining the register to have a wider role in developing surveying methodologies and to maintain a register of surveyors and oversight of their training programs warrants further consideration. The combination of roles suggested may require substantial bureaucratic support and resources. It would inevitably result in some duplication of existing administrative systems, but this may be avoided or minimised if it could be built onto the existing systems that accrediting organisations have in place. An incremental approach should also minimise the costs of compliance. The ACHS believes there is substantial interest and goodwill existing to support such an objective.

The independence of the national body, as reflected in its governance arrangements and role, would be an important influence on public perception as to transparency in the monitoring of performance. The final form would need to maximise public confidence and provide for a clear separation between responsibilities for policy/planning, operational activities and the monitoring of performance.

The paper's comments in this area cover an extensive range of other potential functions, for example data collection, survey methodologies, surveyor registers etc., which need to be assessed in more detail. Seeking to find a solution at this stage might impede the early establishment of the register for accrediting bodies.

The ACHS Response

1. Registration of accrediting bodies should be mandatory and a representative body/committee of key stakeholders should be established as the foundation of such a registration authority as per previous consideration of a National Institute for Standards and Accreditation in Healthcare (contained in this paper).
2. The key function of the registration process should be:
 - 2.1. to establish principles for registration of accrediting bodies e.g. ISQua or JAS-ANZ accredited, public access to operating rules etc.
 - 2.2. to maintain the register in a publicly accessible and useful format.
 - 2.3. maintain links with key stakeholders, including governments, the private sector, other third party funding entities and consumers.
 - 2.4. identification and prioritisation of national issues regarding surveyors.

2. Standardise accreditation language and definitions

Commission question:

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

Comment

The Discussion Papers suggestion for the language and definitions of accreditation to be standardised to help with reducing the fragmentation of the accreditation systems and increase consistency between the accreditation bodies is supported. It is also suggested that standardisation of language is necessary to support mutual recognition of standards by all accreditation organisations.

The ACHS, as with other accrediting organisations, has developed over time a glossary of terminology and standardisation of format that is well understood by member or participating health care organisations. None the less the ACHS is willing to support a common approach and would seek an active involvement in the process.

The ACHS Response

1. The ACHS supports a national body undertaking a consultative process aimed at the standardisation of language and definitions. It will, among other purposes, enable the achievement of mutual recognition of standards and survey outcomes.
2. All accrediting and standards setting bodies should be involved in the process.
3. Once agreed, the requirements for standardised language and definitions should be part of the requirements for registration of standards by the national body (as previously discussed).

3. Training and competency testing of surveyors

Commission questions:

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

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

Comments

The Discussion Paper suggests that the success of any reform in health care accreditation depends on the re-orientation of surveyors to a new approach of accreditation. Whilst the ACHS does not fully support the implication that a completely new approach is required, the proposal to review training and assessment requirements of surveyors is nevertheless a constructive step worthy of development.

The further suggestion to introduce core training requirements for health care accreditation surveyors in order that there can be development of reciprocal training programs is a positive step. With the number of voluntary surveyors available becoming increasingly problematic, a common approach to training would facilitate those who are interested in being skilled in several programs. They could declare their availability to several accrediting bodies and/or be able to proficiently carry out surveys against multiple sets of standards during integrated survey visits. Specialisation of surveyor requirements is a considerable risk to the provision of the overall voluntary surveyor workforce and the introduction of more service specific standards creates a very likely impact that more surveyors will be required.

These issues require considerable thought and there is a risk that gains already achieved in improving the surveyor workforce could be lost. The focus should be on developing existing surveyor skills (rather than replacing them with an entirely new

set of skills). The ACHS is assured by a number of its members that there is now much greater confidence in standard and consistency of surveyors and the ACHS would see that it is important that any new process does not put this at risk.

The ACHS Response

1. The ACHS requires surveyors to have the following qualities:

Skills

- Communication – both oral and written
- Substantial health system experience
- Surveying techniques
- Analytical ability
- Conflict management/negotiation

Competencies

- Contemporary knowledge of the Australian health system
- Knowledge of standards

Attributes

- Commitment
 - Availability
 - Objectivity
 - Balanced judgment
2. A common core set of training requirements should be developed and integrated into accredited training programs as a prerequisite for recognition on externally certified training programs.
 3. Surveyor training programs should be required to achieve external certification.

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

Commission question:

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

Comments

The ACHS agrees that the current approach to data collection is fragmented, under-utilises the data that is already collected and as a result limited patient centred information relevant to accreditation is produced. These inconsistencies were some of the influences that prompted the ACHS to commence publishing its bi-annual review of accreditation performance as well as other reports such as: multi-year trended data reports in respect of clinical indicators (and the subsequent use of that information in survey visits); the strategic performance analysis (SPA) reporting program that can provide both qualitative and quantitative information (targeted or generalised) on either an organisation or cluster of organisations over time.

The exploration of opportunities to develop a more comprehensive picture of health care service outputs and outcomes by combining the data from a number of collections in a centralised model is a very worthy objective that would be supported by the ACHS. The ACHS is aware, in general terms, of the work currently being undertaken by the Commission in this area. The ACHS believes that it is critical to focus such efforts at a national level. Many of the difficulties that exist in reporting data nationally relate to the specific requirements of data at a state level; resulting in there being little opportunity of reliable data comparison and coordination.

The ACHS Response

1. The ACHS supports the development of a more comprehensive picture of health care service outputs and outcomes by combining the data from a number of collections in a centralised model. It would substantially assist it in adopting a more targeted approach to systems review when undertaking surveys.

5. System wide accreditation against safety and quality standards

Commission question:

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

Comment

The Discussion Paper suggests that there is a need to ensure all health services participate in a registered accreditation and quality process. It is envisaged that minimum safety standards will be implemented across all health services through this process. Both of these points are supported, however, there will need to be extensive consideration of the impact on the scope of services that would be encompassed in the requirement of mandatory accreditation (for example, doctors rooms undertaking surgical procedures).

The ACHS has a traditional position of supporting a generic accreditation program with condition/service specific standards only being developed where there is a clearly identifiable need based on performance expectations and/or outcomes. This position supports maintenance of a cost efficient and effective quality regime. There are also practical reasons behind this position, namely a desire to minimise the burden of accreditation and the availability of surveyors with the appropriate attributes.

For example, rather than suggesting that all health services need to be accredited in their entirety, in some circumstances it may be more appropriate to identify an activity focussed on either a known national patient safety priority area such medication safety or a high-risk function such as governance as a priority.

The ACHS Response

1. The ACHS supports all known high-risk activities being required to be accredited separately or for such risks having standards designed to minimise their impact incorporated into generic programs.

6. Introduction of unannounced surveys

Commission question:

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

Comment

The use of unannounced visits has been of interest for a number of years, but the reaction of participating organisations has been varied. One strong view expressed has been that unannounced visits would change the quality improvement focus to compliance, whilst others expressed the opinion that such visits would be valuable from a risk management perspective. Another strongly expressed view has been

that the results of such visits should not form part of the process for determining the accreditation status of an organisation.

In principle the ACHS supports the concept of unannounced surveys, however, there needs to be some careful consideration of the proposal given the significant impact its introduction is likely to have on the industry. The American model, on which this proposal is based, has not been formally evaluated and comment in published articles in refereed journals is limited. However, the ACHS proposes that an evaluated trial be conducted of unannounced surveys. Details such as if there are exceptions for which notice periods should be applied, the process for selecting areas/services etc. are all matters that should be evaluated. The ACHS itself would be very interested in either undertaking the study or facilitating the study within its membership. The purpose of this would be to assess appropriateness in an Australian context, identify preferred options and identify pre-survey data submission requirements for the introduction of unannounced surveys.

The ACHS preference is that unannounced surveys be used:

- a. To complement the Organisation-Wide Survey;
- b. To replace the current Periodic Reviews; and
- c. To focus on specific topics (services or issues), which would vary over time and possibly by location.

The ACHS Response

1. An evaluated trial of unannounced surveys be conducted to identify and assess the appropriateness of their introduction in an Australian context as well as to identify the most appropriate methodology for unannounced surveys in the Australian health sector.

7. Introduction of Tracer Methodology in external accreditation reviews

Commission question:

What needs to be done and by whom, to introduce Tracer Methodology in a timely and effective way?

Comment

The proposal for the introduction of the 'Tracer Methodology' nationally by all bodies accrediting health services is worthy of further study. The intent of this methodology is to track an individual's experience through the health care treatment and service provision and one of the benefits is a strongly consumer focused assessment of a health service. Acknowledgement in the Commission Discussion Paper that this is a new strategy for which there is no evaluation data available as yet gives weight to the need for further research.

ACHS surveyors do use a version of this approach currently but not in the highly disciplined way advocated by the American model. Concerns are held by the ACHS as to the issues associated with case selection techniques necessary to avoid sampling errors.

The ACHS Response

1. The ACHS supports the conduct and evaluation of a study of the use of Tracer Methodology in an Australian context.

8.2 Standards Reform Strategies

8. Registration of sets of health care standards

Commission questions:

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

Which organisation is best placed to manage the longer term register of standards?

Comment

The ACHS supports the concept of registering standards. However there is a great deal of detail that is not considered in the Discussion Paper. It is not clear what the scope of the proposed registration process would be, nor is the purpose of the proposed process explicitly stated. It is difficult to understand if the question posed refers to merely a centralised register of all sets of health care standards or whether a process of restriction is being suggested. The composition and governance of the registration entity is not articulated which compounds the difficulty in being able to respond to the posed questions in a meaningful way.

The ACHS Response

1. In supporting the creation of a register as a requirement for formal recognition of a set of standards, the ACHS would recommend that registration would involve only the following steps:
 - Recognition of need
 - Accreditation of the standards by an external recognised body
 - Compliance with the Commission's requirements in relation to language and definitions.
2. The ACHS has considered the registration of sets of health care standards in the model of the National Institute for Standards and Accreditation in Healthcare as previously proposed in this paper.

9. Harmonisation of health service standards.

Commission questions:

What are the barriers to the standardisation of language and definitions?

Who needs to be involved in this standardisation process?

Comment

The proposal that the language and definitions of accreditation be standardised and that guidelines for the convergence in the format and structure of standards be developed is supported. The ACHS believes there are few barriers to overcome other than the traditional positions of current standards setting and/or accrediting organisations which is probably no more than a reflection of the lack of a mechanism in the past to achieve this outcome. A meeting of such bodies and other stakeholders should be convened to devise a project to identify standard language and definitions and the ACHS would enthusiastically wish to be part of this process.

The ACHS Response

1. The ACHS is of the view that there are few barriers to standardisation of language and definitions, but rather the current situation is a reflection of the lack of a mechanism to achieve this outcome.

2. A meeting of major accrediting and standards developing organisations and other key stakeholders be convened to devise a project to identify standard language and definitions.
3. Once agreed the use of the standardised language and definitions could be incorporated into the requirements for registration of standards with the National Institute for Standards and Accreditation in Healthcare.

10. Detailed mapping of standards

Commission question:
Who needs to be involved in this mapping process?

Comment

For more than five years the ACHS has observed the significant increase in the number of sets of standards used in the health industry. Member organisations have consistently expressed concern as to the need for, and cost of, complying with an increasing range of standards. There is also a considerable risk that the growing number of standards focussed at a particular clinical specialty will erode the organisational perspective that is essential in all current risk management and safety programmes.

The ACHS suggests that the proposal to undertake a detailed process of analysis and mapping of existing Australian health care safety and quality standards is premature. Prior to any mapping process the ACHS believes that it is necessary to establish the governance framework for the national body that will register standards setting and accrediting bodies; a process which will incorporate the issue of language and definitions as well as minimisation of the number of standards.

To undertake a mapping exercise would result in effort being wasted on reviewing programs that may have to be changed substantially. Submission of standards for registration would provide an entry point for proposed standards to be mapped.

The ACHS Response

1. Whilst the ACHS supports undertaking the standards mapping exercise, it regards it as a second order issue that should not have resources allocated until such time as a decision is made in relation to the issues such as registration of standards, and standardisation of language and definitions.

11. Identification of core safety quality areas

Commission question:
What priority areas should be included in core safety and quality standards?

Comment

The proposal that the Commission identify a core set of safety and quality areas that are to be reflected in all registered sets of health safety and quality standards is supported. However, it may be difficult to determine what these core standards should be. The previous Council identified national priorities for patient safety and these could well form the basis of core clinical standards. Another option to consider is the list of areas identified by the World Health Organisation through its Global Patient Safety Alliance.

In addition to clinical areas, the ACHS would argue that governance standards should be underpinned by (common) core standards given the importance of

organisational leadership in creating and maintaining a culture of safety within any organisation.

The ACHS suggests that the identification of the core safety and quality standards should be incorporated into all sets of registered standards. Ideally the identification of the core standards would be the responsibility of the National Institute for Standards and Accreditation in Healthcare. Given that this organisation is well placed to undertake research to identify the core standards as well as then apply those requirements to both standards and accreditation (through the proposed processes of registration for each separate function).

The ACHS Response

1. Core standards for safety should be a consideration of a national body in order that the focus remains at a higher governance level that can then be incorporated into the relevant sets of standards at a more operational level.

8.3 Mutual Recognition of Standards and Accreditation Process

Commission question:

What is required to implement mutual recognition of standards and accreditation processes in the Australian health care system?

Comment

The proposal that the Commission work with stakeholders to remove duplication and overlap in the standards and accreditation system, including that which exists for accreditation of education and training programs is supported. However, the ACHS believes that addressing the process for mutual recognition of standards can only be considered following the establishment of a national body that will have governance responsibility for standards through a process of registration. Registration of standards will provide the basis for mutual recognition and matters regarding the mutual recognition of standards and accreditation processes should only occur after the process for registration has been finalised.

The ACHS Response

1. The ACHS holds a developing view that this issue should be progressed following agreement as to a national framework for standards recognition and accreditation programs. The establishment of core standards for safety together with standardisation of language and definitions would be important first steps in facilitating a national system.

4. Attachment – general comments on some aspects of the Discussion Paper

The following comments relate to selected references in relation to sections 1 – 5 of the Discussion Paper.

Reference	Comment
Page 1 final paragraph	The reference to “stricter controls” is misleading as fundamentally there are no controls at present other than those developed and applied by the various entities that generate standards.
Page 2 referenced document No. 3	This document is not publicly accessible. It would be appropriate if access was provided if it is to be cited.
Page 4 3 rd paragraph	The reference to Standards Australia being recognised by the Commonwealth Government as the peak non-government standards development body is not consistent with advice the ACHS received previously from the office of the Federal Minister for Health and Ageing. That advice qualified that the Commonwealth did not envisage that this level of recognition of Standards Australia applied “in specialist areas such as health care”.
Page 6 2 nd paragraph	The ACHS disagrees with the assertion that the original focus of accreditation was on minimum safety requirements. As the oldest such program in Australia by many years the original emphasis of its program was on continuous quality improvement with a focus on the structure and business systems of hospitals/health care organisations. In the mid 1990’s this emphasis was modified to embrace ‘outcomes’.
Page 6 5 th paragraph	The broad conclusions of the Australian Research Council funded project as to the effectiveness of accreditation are expected to be available by August 2007.
Page 7 5 th paragraph	The comment attributed to Standards Australia seeks to make a distinction between ‘accreditation’ and ‘certification’ in terms of enhanced consumer utility. Such a distinction is obscure. The rationale is further complicated by the costs associated for consumers in accessing Australian Standards, which are retailed only by SAI Global.
Page 7 Last paragraph	The implication appears to be that consumers are entitled to access information on accreditation merely for the purposes of selecting a service for their own use. This view is somewhat limited if one considers that the public significantly contribute to the funding of health services (in both the private and public sectors) and are in that regard entitled to information about accreditation status of services whether or not they intend to use them.
Page 9 Item 5	Health insurers do not set standards and to imply that they do in the context of the other organisations mentioned is misleading. Health insurers may have contractual criteria with health providers regarding matters

	of performance, but these have a purpose which is not at all aligned the other organisations described.
Page 11 2 nd field	The Australian Diagnostic Imaging Association is the 3 rd signatory to the MOU under which this program is being developed.
Page 11 3 rd field	NATA is not the accrediting organisation. It is the performance assessing organisation.