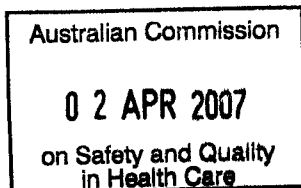


ROYAL AUSTRALASIAN COLLEGE OF SURGEONS



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29 March 2007

Dr Diane Horvath AO
Chief Executive
Australian Commission on Safety and Quality in Healthcare
GPO Box 5480
SYDNEY NSW 2001

Dear Dr Horvath

National Safety and Quality Accreditation Standards

Thank you for the opportunity to comment on the Australian Commission on Safety and Quality in Healthcare discussion paper *National Safety and Quality Accreditation Standards*.

Please find attached a submission from the Royal Australasian College of Surgeons.

I should be pleased to discuss any aspect of our submission should you wish, and look forward to the opportunity for further discussion about this important issue.

Yours sincerely

Dr Ian Dickinson
Chair, Professional Development and Standards Board

cc:
Dr Russell Stitz, President RACS
Mr Andrew Sutherland, President Elect RACS
Dr David Hillis, Chief Executive Officer, RACS
Dr Pam Montgomery, Director Fellowship and Standards

National Safety and Quality Accreditation Standards

Submission by the Royal Australasian College of Surgeons



The Royal Australasian College of Surgeons is pleased to make a submission to the review of standards and accreditation for health services in Australia as we believe that this is critical to the continuous improvement of the safety of surgical practice in this country.

It is important to ensure that comprehensive, transparent and accessible standards are developed and maintained according to best practice principles; that rigorous accreditation systems are in place to reliably measure the extent to which health care organisations meet or exceed these standards; and that the accreditation process is able to identify and respond appropriately to any significant failure by an organisation to meet the standards.

Accreditation – what does this mean?

Despite advances in the area of quality and safety of the health sector over the last 20 years significant questions remain unanswered. A 'reality check' is now fully warranted. In many ways the accreditation and standards industry has been captured by interest groups and self professed experts. An enormous amount of time, effort and resource is applied in achieving standards too focused on policies and processes. This may have been appropriate last century when issues of quality and safety were not clearly on the health sector's agenda. Substantial gains have been made in properly understanding the infrastructure requirements and the importance of reliable processes and policies.

Community understanding of accreditation is far more fundamental. They expect healthcare will be safe and care will provide the desired outcomes. Public expectations often outstrip the realistic capacity of both the individual professional and the health care organisation. Despite this, there is justified expectation that the individual patient will not be harmed. Consequently success in the accreditation process but an inability to prevent harm to patients is self-contradictory.

Consequently any integrated package of reforms must aim to:

1. Reorientate accreditation to focus on patients
2. Increase the links to patient outcomes
3. Standardise the processes
4. Identify mechanisms that detect systems failures

Accrediting the accreditors

The College has for a substantial period of time been concerned how a group of individuals can self-proclaim themselves as experts or standard setters in a particular area. The Australian Medical Council has done much in the vocational educational arena to register bodies and ensure that language is standardised. In a compelling way this also needs to be applied to the groups that establish standards and others who provide the accreditation. Unfortunately an industry has been developed that is often seen to be self enforcing and maybe self gratifying. As a consequence they have lost much of the support of the active clinicians who care for patients in our health care facilities.

One of the largest concerns with any form of assessment is consistency and reliability. The assessors are vital in ensuring that the standards to be achieved are clearly understood and that the patient orientated perspectives of this are highlighted. The current accreditation process allows for variable interpretation beyond what is required by flexibility. Equally of concern is that some organisations are accredited when they clearly fall far short of a safe environment for patients. A degree of urgency and enforcement needs to be felt with the accreditation activities and the penalty for non-compliance needs to be far more explicit. Currently, a hospital can lack the infrastructure or ability to provide safe care but they can

remain open for many years. Such an outcome is no longer acceptable and nor should it be connived at by hospital administrators or by the jurisdictions under which they work.

Equally the accreditation process needs to be effective and the College acknowledges the ten principles as established in 2003 by the UK government. These are:

1. The purpose of an external assessment is to pursue improvement
2. The focus of an accreditation visit is patient outcomes
3. The patient's perspective is the lens through which surveyors should assess services
4. The assessment effort should be proportional to the risk
5. Managers should be encouraged to undertake self assessment
6. Impartial evidence should be used where possible
7. The criteria used to assess services are disclosed
8. The process is open and transparent
9. The assessment process has regard to value for money, including that of the inspecting body
10. The assessment process supports continuous improvement and continual learning.

Focus needs to be on the patient and patient safety

The College remains concerned that the focus on clinical review and peer review of clinical outcomes is not clear. It should be mandatory for all hospitals to have active clinical review in all areas and this should be as tangible as the financial audited accounts or with as much vigour as is brought by NHMRC constructed ethics committees. A hospital must be judged on the safety of its clinical practice. Whilst issues of economy, efficacy, efficiency and access are important, they cannot overwhelm issues of safety and quality. The College is not requesting a continuous 'gold class' of clinical activity. It is requesting that the outcomes of patient care are reviewed and that at a local level the variances beyond the expected are routinely analysed. Following this analysis there needs to be a loop of continuous improvement to ensure the hospital systems are improved or individual practitioners more appropriately trained and updated. These activities need to be reported to the Board as routinely as variances in the financial reports.

The College is well aware of the Clinical Indicator program undertaken by ACHS. Whilst the indicators have some value in ensuring that an individual hospital is collecting some clinical data, they are narrow in their focus as they need to be understood across multiple areas. The idea of having benchmarked activities is highly appealing. However what is required is that the local hospital can have confidence that all their patient interactions are safe. They are quite different outcomes. Although the current system of accreditation and collection of clinical indicators has contributed substantially to raising awareness, it is most important that the safety issues are now moved forward.

Delivering safe patient care

The College believes that:

1. Qualified clinical staff must be appointed
2. A program of meaningful CPD and re-affirmation of skills as a prerequisite for re-accreditation must be mandatory
3. Routine audit and appropriate national registries with the capacity to ensure that all variances are scrutinised and acted upon are essential, and such processes must be appropriately constructed
4. Audit must be undertaken at the local level and also in collaborative large group studies including national audit.

Qualified clinical staff

The appointment and credentialing process has been progressively revised over the last five years. The College supports the guidelines distributed by the previous Australian Safety and Quality Council. Credentialing within the local hospital is most important to ensure a safe service with adequate infrastructure and the critical mass to ensure access requirements do not compromise quality. The staff appointed should have qualifications that are verifiable by the Australian Medical Council or equivalent professional College. They should also provide regular documentation about their ongoing professional development including involvement in rigorous peer review.

Hospitals should also provide ongoing support to clinicians by facilitating their access to professional development and peer review, and by ensuring appropriate support when there has been a significant adverse event.

Ongoing review and audit

Audit of clinical work does not occur without organisational commitment and local enthusiasm. Most clinicians actively wish to see this occur and are keen to be involved. However this requires preparatory time, information technology support and dedicated administrative support for data collection. All hospitals regard this as important but the issue is one of priority. Review of all clinical activity and key variance analysis can be achieved by making this a compulsory component of accreditation for the organisation and credentialing of the clinician. Substantial amounts of money are now committed to administrative processes. With this accreditation requirement the clinical audit and review process will have a competing importance.

It is critical that appropriate peer reviewed audit processes be instituted universally, and are properly funded and privileged. Clinician support will be achieved only with proper systems and adequate funding.

Registries of activity

Several registries are already well developed across Australia but lack cohesion and have incomplete roll-out. Without the cohesion and the completion of implementation the key improvements to health care systems and clinical approaches cannot be achieved. It will be vital to ensure that a small number of compulsory registries are identified for each hospital and that other registries are appropriately reviewed and recommended as optional. An example of this process is the Surgical Mortality Audit that is supported by each State Government and co-ordinated by the College. By having comparable data sets across all of Australia trends in issues like DVT prophylaxis, ICU support and presence of Consultant Surgeons can be identified both at an individual hospital level and at a systems wide level. All hospitals with surgical activity need to be part of this. The Breast Audit which is also maintained by the College is more focused with input from Breast Surgeons and follows up issues of treatment and outcomes. Other examples include the Joint Registry conducted under the auspices of the Australian Orthopaedic Association and the Trauma Registry which is under the auspices of a number of bodies including the College.

Similarly, the Trauma Verification program is a multi-disciplinary process developed through the College to assist hospitals to analyse their system of care for injured patients from pre-hospital through to discharge from acute care. The program has tremendous potential to allow hospitals to benchmark their services against acceptable and international standards of trauma care and is directly linked to measurable patient outcomes.

Summary

The College is highly supportive of the review of standards and accreditation as they relate to health care. The last 20 years have seen substantial improvement in infrastructure, policies and procedures that support the activity of health care. However it is now time to move forward, to re-focus the initiatives on ensuring the safety of patient care, the focus on patient

outcomes and the comparability of outcomes across the country. The College applauds the intent to simplify the processes and improve the comparability and mutuality of accreditation bodies. The key issue is that we now need to focus on the quality and safety of health care itself. We will need to ensure there are highly qualified staff who are committed to ongoing development and peer review and audit. However, they must be given the tools, resources and profile so these can be fully undertaken locally and compared at a national level. Furthermore, rigorous accreditation processes need to be in place to ensure that standards are at least met, if not exceeded. Such processes need to have enforceable sanctions to have any chance of success.

Finally, we are aware of the challenges that will be involved in implementing any significant changes to accreditation standards, particularly at a clinical level. Therefore we suggest that the initiatives are part of the Australian Health Care Agreements in 2008.



Dr Ian Dickinson FRACS
Chair, Professional Development and Standards Board
Royal Australasian College of Surgeons

29 March 2007