

# ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

Patron, H.R.H. The Prince of Wales



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Professor Chris Baggoley  
Acting Chief Executive  
Australian Commission on Safety and Quality in Healthcare  
GPO Box 4580  
SYDNEY NSW 2001

Dear Professor Baggoley

## **An Alternative Model for Safety and Quality Accreditation of Health Care**

The Royal Australasian College of Surgeons thanks you for the opportunity to submit comments on the Consultation Paper for "*An Alternative Model for Safety and Quality Accreditation of Health Care*".

Our submission is attached.

I would be most happy to discuss any aspects of our submission further.

Yours sincerely

Dr Ian Dickinson FRACS  
**Chair, Professional Development and Standards Board**

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cc Dr Andrew Sutherland, RACS President  
Dr David Hillis, RACS Chief Executive Officer  
Dr John Quinn, Executive Director for Surgical Affairs  
Dr Pam Montgomery, RACS Director, Fellowship and Standards

# **AN ALTERNATIVE MODEL FOR SAFETY AND QUALITY ACCREDITATION OF HEALTH CARE**

## **SUBMISSION OF THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS**

The Royal Australasian College of Surgeons is pleased to make a submission on the Consultation Paper “*An Alternative Model for Safety and Quality Accreditation of Health Care*”. We feel this is a critical aspect of the continuous improvement of the safety of surgical practice and care of our patients 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 accreditation processes are able to identify and respond appropriately to any significant failure by an organisation to meet those standards.

### **1. Separation of safety assurance and quality improvement assessment processes**

Because there is some confusion in the current accreditation process merging both safety assurance and quality improvement into processes, standards and recommendations, we agree with the proposal to separate the setting of safety standards and processes to measure safe delivery of care from quality standards settings and assessment processes. However, we strongly feel that the providers of care must be involved in this process. The standards setting bodies, who will develop and maintain quality improvement standards, need to be heavily influenced by clinicians and providers of such care.

For meaningful safety assurance and also quality improvement processes, accreditation, meaningful CPD and funded audit are all important to maintain, and to be seen to maintain these standards, and to demonstrate to the community that safety assurance is important, and further that there are processes for quality improvement assessment based on this audit.

It is vitally important that to be effective, the providers of this care must feel ownership of the process to make it integral and important to everyday practice.

Whilst this separation of safety assurance and quality improvement assessment processes is important, any reforms must aim to:

1. Reorientate both safety assurance and quality improvement to focus on patients.
2. Increase the links to patient outcomes.
3. Maintain openness of the standardisation process.
4. Identify mechanisms that detect system failures.

### **2. Separation between safety standards development and assessment of health services**

We support the separation of safety standards development and the accreditation assessment. However, to progress this appropriately it is vitally important again that there is clinical input in the setting of such standards and their achievability.

Whilst the separation of accreditation assessment of health services is laudable, the College has been concerned for some time that a group of individuals can proclaim itself expert on standard setting and accreditation in a particular area. Furthermore, there appears to be a range of different accreditation bodies all of which purport to be expert, yet at times appear to duplicate the standard setting processes, some of which are not always compatible. Clinicians are sceptical of an industry that has developed but which can be seen to be self-enforcing and may be self-gratifying. As a consequence these bodies have lost clinician support.

The Australian Medical Council has done much to further standards in the vocational education sector through accreditation of registered bodies and by ensuring that language is standardised. This has been a useful model.

It is important that clinicians are involved and feel confident and satisfied that the accreditation assessment of health services has appropriate clinical input and that clinicians are involved in the accreditation assessment in a direct way.

As outlined in our previous submission, one of the greatest 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 orientation perspectives of these are highlighted. Currently accreditation processes allow for variable interpretation beyond what is required by flexibility.

In our original submission we brought to your attention that some organisations are accredited when they clearly fall far short of a safe environment for patients, and that a degree of urgency and enforcement was needed to deal with the accreditation activities. The penalty for non compliance needs to be far more explicit.

We would like to reiterate that for the accreditation process to be effective, 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 outcome
3. The patient's perspective is the standard to which services should be assessed
4. The assessment effort should be proportional to the risks
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.

Whilst we accept that it is appropriate to assess against National Standards, any national collection of data must be adequately funded to allow this to be accurate and appropriate.

### **3. Accreditation of all settings of care where services are provided by registered health professionals**

Whilst it may be laudable that health services provided by any registered health professional will need to comply with national minimum safety standards, at this stage it seems an unachievable aim.

We feel that the effort in maintaining safety and quality should be focussed initially on Hospitals, Medical Centres and Institutions, rather than on individual health professionals' offices. This may be achievable at a later time.

### **4. Development of national minimum safety standards that apply across all (similar) settings of care**

The College recognises that there are a number of different standards and different frameworks against which safety is measured throughout Australia. Several registries are already well developed across Australia to assess this, but they lack cohesion and have incomplete rollouts. It will be appropriate to ensure that a small number of compulsory registries are identified to ensure national minimum safety standards, that the keeping of

these registries and datasets is appropriately funded, and that there be clinical input by active practitioners into the setting of such minimum safety standards.

Compliance with maintaining compulsory registries is a particular problem and if national minimum safety standards are monitored by over zealous, complicated and confusing datasets, this aim will be unachievable.

For example, by having comparable datasets across all of Australia, assessing issues such as DVT prophylaxis, ICU support and the presence of Consultant Surgeons in the operating room can be identified, both at individual hospital level and at a national level. All hospitals with surgical activity need to be part of this process

## **5. Assessment of non-clinical and technical compliance**

The proposal to standardise safety assurance accreditation processes, including minimum safety standards, non clinical regulation and technical compliance, by a system of mutual recognition we feel has merit.

We recognise there are currently differences in jurisdictions throughout Australia that require different compliance standards, and this is often confusing and regularly duplicated.

Whilst this aspect can be improved with a standard regulatory environment, again clinicians need to be involved in this process because these aspects invariably impinge on patient treatment and subsequent outcomes.

If this regulation extended into assessment of prostheses and medical devices without surgeons direct input, we feel this would be a backward step.

## **6. Development of a national framework for quality improvement**

The aim for the development of a national framework for quality improvement is laudable and may be achievable, but again it requires clinical input to be accepted and successful. The Royal Australasian College of Surgeons already participates in such a national framework using ASERNIP-S. This looks at new surgical interventions and procedures from the point of view of safety and efficacy. It has been very successful in the surgical arena, and is a model that works particularly well in the surgical environment.

## **SUMMARY**

The College is highly supportive of the process and the alternative model put forward. We accept that whilst there have been substantial improvements in such activities over the last ten years or so, there are improvements that still can take place. They will not be achieved in the short term as they have quite significant resource implications.

It is vitally important that all of these activities - regulation, registries and compliance with datasets - have significant cost implications and must be appropriately funded by the jurisdictions and the hospitals.

We feel it is time to move forward and to refocus the initiatives in ensuring safety of patient care and on patient outcomes.

The College applauds the intent to simplify the processes and to improve the comparability and mutuality of accreditation bodies. As in our previous submission, we would like to repeat that we will need to ensure that highly qualified staff who are committed to ongoing development and peer review and audit are involved. However, they must be given the tools, resources and profiles so that these can be fully undertaken locally and compared at a national level.

Further, such processes need to have enforceable sanctions to have any chance of success.

The College is well aware of the challenges that are involved, applauds the intent, and signals our wish to participate. It is vital, however, that at all stages there is clinical input and that the process is adequately funded.

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