Response from Australian General Practice Accreditation Limited and Quality in Practice Pty Ltd

to

The Commission on Safety and Quality in Health Care "Consultation Paper: An Alternative Model for Safety and Quality Accreditation of Health Care"

October 2007

Introduction

As a not for profit profession governed organisation, Australian General Practice Accreditation Limited (AGPAL) and its subsidiary Quality in Practice Pty Ltd (QIP) are committed to improving outcomes for practices through the process of accreditation and participating in the wider quality agenda. AGPAL and QIP have participated in the consultation process on accreditation reform being led by The Commission on Safety and Quality in Healthcare and are keen to continue to comment on the reforms being proposed. We do this from the perspective of an accreditation company and defer reference to standards development to the professions with which we currently work, namely the Royal Australian College of General Practitioners (RACGP), Optometrists Association of Australia (OAA) and Australian Physiotherapy Association (APA).

Executive Summary

As a summary of the major responses included in the following paper, QIP/AGPAL :

- Recommends that there be no “artificial” or real separation of quality and safety – the two are necessary to assure consumers of the provision of safe, quality practice.

- Supports the proposed separation of standards development from assessment of health services.

- Supports that all health services provided by any registered health professional comply with safety and quality standards as defined by accreditation.

- Supports the development of national minimum safety standards which sit within a national minimum safety standards framework.

- Supports that avoidance of possible duplication and co-existing burdens of accreditation through mutual recognition.

- Supports the principle of a quality improvement framework implemented across all health services.

- Agrees in part with the concept of a national coordination and stewardship body. However, we disagree with the scope of its management as proposed.

- Supports a review of surveyor training providing that there is tangible support and resource allocation to allow this to occur.

- Considers the significant associated reforms being (1) mutual recognition of processes and outcomes across healthcare dimensions to reduce duplication and service burden and (2) the concept of unannounced surveys if (a) such an approach offers more efficient and effective visits to assist in containing costs of accreditation participation and (2) it assists to position safety and quality as an ongoing and continuous process for health practice.

1. Separation of safety assurance and quality improvement assessment processes

Proposal:

The alternative model proposes separating safety standards setting (and processes to assess them) from quality standards setting (and processes to assess them). Safety assurance and quality improvement will be subject to different compliance and reporting requirements. Safety assurance will be prescribed through minimum safety standards, while quality improvement will be delivered within a framework which encourages continuous improvement.

QIP/AGPAL Response:

There should be no "artificial" or real separation of quality and safety – the two are necessary to assure consumers of the provision of safe, quality practice.

Basis for Response:

1.1 To the appropriateness and effectiveness of separating safety assurance and quality improvement;

To achieve safety, a commitment to quality through culture and leadership is essential. We believe that separating the two sends the wrong message. The production of a minimum set of safety standards, whilst being an initial positive step in encouraging a broader range of healthcare disciplines to participate in the safety agenda, downplays the inter-relatedness of elements required to run safe, quality practice. An agenda of change around safe quality practice requires governance and leadership; the separation runs the risk of focusing on clinical outcomes as safety is just one dimension of quality. The point of quality is to improve safety, and quality must be the central value.

Secondly, the proposed dual compliance and reporting requirements has the risk of further adding to clinical and practice burden.

However, most importantly, systems improvement should be aimed at continuous improvement and best practice over time, and the proposal relegates it as "an optional extra", and not central to the agenda of continued quality practice.

There is a gap in quality between those that are currently engaged in the process and those that are not engaged. The model needs to close that gap and engage all providers to participate in both safe and quality practice. It should also seek out the leaders who have advanced the agenda already to act as guides for those who have not yet begun.

1.2 Timeframes for the implementation of a separation of safety assurance and quality improvement;

We do not believe that the proposed separation is appropriate. However, if the inclusion of at least a set of safety standards in all current processes was enacted, this formal assessment should be required when the next review of standards is due for those agencies which currently have appropriate standards (provided that such review is formalized and occurs on a regular basis). It is assumed that in already existing standards processes, the inclusion of minimum safety standards could reasonably be argued to be included already with only minor adaptation required within already existing standards development frameworks.

If appropriate standards do not already exist, they should be required within a pre-determined timeframe set by the Commission, subject to appropriate articulation of those minimum requirements, informed by an evidence base and currently existing processes should be used, as and when possible, to ensure consistency of approach.

We propose, however, that such timeframes for new standards development should have the additional expectation of progressing the agenda beyond clearly defined minimum safety standards by the central arbitration body and timeframes specified for this to integrate both safety and quality processes.

1.3 The resource implications of this change and funding options that should be considered.

We do not believe that the approach of separating safety standards from quality improvement approach would necessarily be a cheaper option overall. We believe the optimal proposal is to ensure that a minimum group of safety standards is set and the expectation that these, at least, be incorporated in the development of appropriate safety and quality standards according to pre-determined timeframes. This activity could be centrally funded and the results provided for health services as a whole, acknowledging that those processes currently existing are recognised and, for the services currently without safety standards, the development of a core generic “start up” should be achieved in a centralized, effective and efficient way.

The expectation that safety standards act as a platform for further development then encourages the pursuit of the equally important broader quality improvement dimension – both are central to a service being known as “accredited”. The safety standards thus become a line in the sand for participation in standards evolution and funded centrally in a way which allows the resulting property to be shared, but does not act as the limiting factor for health service groups to deter them from further standards development to ensure their relevance and inter-relatedness to the discipline as a whole. Safety standards should act as the core onto which quality standards are developed and implemented through accreditation.

Finally there are significant implications for accreditation providers from the approach of splitting services across quality and safety. As integration is optimal, it should be the goal.

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

Proposal:

The alternative model proposes there be a separation of safety standards development and assessment of health services.

QIP/AGPAL Response:

We support the proposed separation of standards development from assessment of health services

Basis for Response:

2.1 The mechanism for achieving this change

There must be a level playing field for those who use the standards. This is equally so in gaining consistency in assessment (achieved via feedback and data) and also access to the standards to ensure equity and public accountability. The proposal sees a national body responsible for developing safety standards that are endorsed by Health Ministers. This may be appropriate. However, we would encourage the framework to form the minimum standards on which further safety and quality development is demanded

(see 1.0). There must also be the engagement of the professions and consumers in any such group. Accreditation bodies could act as the separate entity through which such are assessed. It is assumed there would also be requirements around external bodies being eligible to do such assessment eg. themselves being externally certified, use of peers etc.

2.2 Timeframe for the implementation

This would depend on the degree of change as defined by the core standards. It is assumed there are several bodies currently in existence to increase the scope of activities to cover broader health care services. Again the nature of the framework would determine if there is the existing competency within such agencies to have a skilled and competent assessing workforce to offer such services and whether peers would be mandated as a part of delivery. The time frame must also be integrated with tangible and significant funding benefits through which participation is encouraged (or sanctioned).

2.3 The resource implication of these changes and funding options that should be considered

There must be financial levers to support participation in safety and quality. If regulators and funders are to regard accreditation as the minimum practice achievement for determination of funding, accreditation must give the confidence through participation, as well as support the business case for safe quality practice. The risk is that participants see it as another burden on their time, rather than central to the provision of high quality and safe practice.

There is also the issue around funding for ongoing standards setting and development. Currently the user pays and this is not the most sustainable model if the goal is consistency across healthcare and if groups not currently accredited are to be engaged. This includes the assurance that there is an ongoing research agenda to support evidence based standards setting to ensure appropriateness and relevance and to ensure clinician engagement in central to the process. Public access to standards should also be an outcome to underpin the confidence and understanding of consumers in the process.

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

Proposal:

The alternative model proposes that health services provided by any registered health professional will comply with national minimum safety standards and implement the quality improvement framework. For services where no accreditation system currently exists, the initial requirement will be compliance with national minimum safety standards and regulatory compliance only. A staged introduction of compliance with the quality improvement framework will follow.

QIP/AGPAL Response:

We support the proposal in which all health services provided by any registered health professional complies with safety and quality standards as defined by accreditation and the staged process proposed.

Basis for Response:

3.1.1 The appropriateness of including services provided by registered professionals, where they are registered in only one or two states and territories;

All services in which registered professionals operate should be required to be accredited, including when such professionals are registered on only one or two states and territories. Quality practice needs to be a partner to professional practice.

3.2 Transition arrangements required to implement the assessment of national minimum safety standards in all settings of care;

Again, this largely depends on the standards determined and the capability of assessing them. It is not assumed that assessment processes must look as they do now. The process of random visits may have a role in both (1) allowing implementation in a shorter time frame and (2) focus quality as an ongoing and necessary part of practice.   One arbitration and process policy must be implemented to which all groups adhere and not differential timeframes imposed due to a particular professional group's circumstances if the national safety initiative is to be fairly and appropriately implemented. A transition approach must be considered to ensure services and providers have adequate time to prepare. Affordability must be considered and also integration with the reforms and legislation such as those currently in private health insurance and COAG. Even though these cover different areas, there must be close alignment and integration.

3.3 A prioritisation process for the staged implementation of changes for services that are not currently accredited;

We believe that an arbitration and process policy must be implemented to which all groups adhere and not have differing timeframes imposed due to a particular professional group's circumstances if the national safety initiatives are to be fairly and appropriately implemented.

The immediate priority should be the groups currently without any formal standards or accreditation framework against which performance can be assessed. This also involves access to applicable standards.

This may mean that the "manner" of implementation must significantly differ from that which standards compliance bodies currently use. The use of the terminology "registered for accreditation" is a powerful driver of change (and the expectation that accreditation will be achieved within a certain timeframe). There is good evidence to show that registering for accreditation, provided there are significant drivers to the process, leads to accreditation, although this may take differing periods of time depending on service readiness. If a national agenda is to be implemented, the timeframe for action should be consistent. The commitment, as evidenced through "registration for accreditation" is not onerous for a service and drives commitment to action. Conversely "achieving accreditation" as an entry point is a much more difficult message to sell in the first instance. The rate at which action is elicited is largely proportionate to the tangible rewards which both support it and drive service demand for accreditation.

3.4 Timeframes for the implementation of safety assessment processes;

Once standards are determined, as above, a clear message that services have to commit (or register) for the process and allow for a clear indication of a time period thence in which accreditation must be achieved. This is usually 12 -18 months, but in such a wide scale project as this, there may be merit in extending this or, alternatively, issuing a form of accreditation upon registration eg. Conditional accreditation which is then arbitrated via random audits rolling over periods of time.

3.5 The resource implication of these changes and funding options that should be considered;

Services need to feel as though there is support for participation in accreditation as well as tangible reward to underpin achievement. Resources implications include (1) standards setting and maintenance (2)

education about participation to remove the barrier of fear and misunderstanding (3) resources to assist participation which often come from the groundswell once participation commences (4) assistance for those who are struggling to meet standards due to a range of reasons (4) resources required to run and develop ongoing arbitration/certification processes (5) having a competent trained assessor workforce to offer the services in a professional and consistent manner and (6) the implications which derive from unsuccessful participation or failure to get accreditation and thus complaints and arbitration which may accompany this.

Some of these eg. Standards development, requires significant monetary investment. Some, such as accreditation, may be legitimately self funded providing that the levers which underpin service engagement are appropriately motivating and allow for sustainability of participation over time.

3.6 Incentives that could be considered

(i) Links with continuous professional programs and appropriate recognition of the activity which accompanies engagement in accreditation eg. QA&CPD programs
(ii) Links with registration and professional pre-requisites for practice
(iii) Funding agency links eg. Private health insurance, Veterans Affairs, Medicare access, Workers Compensation framework.

If quality is to be seen as central to the provision of safe care it must be similarly recognized by external providers as a fundamental business driver to underpin health delivery and, preferably, driven at a national level to ensure consistency and engagement.

4. National minimum safety standards that apply across all settings of care

Proposal:

The alternative model proposes a process to develop national minimum safety standards, endorsed by Health Ministers that sits within a national minimum safety standards framework.

QIP/AGPAL Response:

We support the development of national minimum safety standards which sit within a national minimum safety standards framework.

Basis for Response:

4.1 The criteria and processes for determining national minimum safety standards.

The professional groups impacted upon through standards development have to feel some responsibility for that which is being developed. Professional engagement is paramount. The risk in primary care is "inheriting" tertiary sector standards which may not be considered appropriate nor feasible. We feel the more appropriate model is to develop minimum safety standards/guidelines and the expectation that professional groups will use these as the basis for an accreditation framework. Clinicians, allied health professionals, experts and consumers should be involved in such a central group. There is also a need to ensure common definitions and language to push consistency across disciplines.

4.2 The areas to be addressed by the standards and the coverage of each standard;
4.3 The priority order for the development of standards, which may be risk-based;

We are not a standards setting organisation so defer comment on these issues to the RACGP or other standards setting bodies such as OAA or APA with whom we have professional association through standards development.

4.4 Whether the assessment outcome against minimum safety standards should be pass or fail
4.5 Under what circumstances a 'fail' rating would be applied;
4.6 Sanctions or penalties that would result;

There are very real connotations with the concept of "failure". Meeting standards involves a process of education, understanding, self assessment, external review and reporting (and, in some cases remedial action). Should such action not result, failure will result. To have an approach when pass/fail are the only two options would be to undermine the value of continued learning as a tool towards safe and quality practice, particularly for services which may be engaging for the first time in external assessment.

This is not to say that sanctions do not result if a service does not meet a designated set of standards. These could be used as significant levers towards compliance and performance. However, the concept of failure as a general principle should only be implemented once consultation has occurred as to the real and perceived effects of what such terminology implies, both to professionals and consumers.

4.7 What a failure would mean for a health service;

In a positive and educational framework, not meeting standards may potentially lead to the inability to access benefits associated with standards compliance, an understanding as to the steps required to be able to meet the standards and pre-determined time frame for such action.

Conversely, a loose and limited view of "failure" may lead to loss of public confidence in the safety and quality framework the reform is intending to introduce and similarly by the professionals and services engaged in this national initiative.

4.8 Mechanisms to ensure mandatory compliance against national minimum safety standards.

This may be a combination of assessment processes and self assessment, with ongoing accountability (whether that be annual statutory declarations or similar endorsing that no significant changes have occurred to compromise the accreditation status). The most powerful mechanisms exist in access to funding as a result of compliance.

4.9 Options for assessing national minimum safety standards and mechanisms to reduce the subjectivity of the outcome and inter-assessor reliability.

100% of services will work towards self assessment culminating in their belief that their service meets the standards. Experience has shown that the compliance numbers, when externally assessed, are significantly less. The ability to assess the degree to which systems are integrated into practice can only be fully reviewed by a visit (random or otherwise). Any process determined by desk top audit alone would be a process evidencing reliance on written documents and would be of only limited value. The multi faceted data which is used to build a true picture of the meeting of standards is rich and paints a true picture of service improvement areas.

There are mechanisms to improve inter-assessor reliability. QIP/AGPAL has developed a tool to limit the range of options which has been harnessed through experience to limit the judgement sphere which surveyors operate, yet allowing for the ability for individual circumstances to be noted to provide contextual

reference. This has resulted in demonstrated improvements in decision making. Electronic tools can continue to assist this process and respond to the challenges in inter-surveyor reliability.

The use of surveyors across professional groups may actually enhance this current process and provide greater certainty for consumers that there is a less profession-guarded approach to assessment regimes.

4.9 Mechanisms to recognise bodies to assess against national minimum safety standards.

QIP/AGPAL supports the concept that recognition of conformity assessment bodies should themselves have an external form of certification/accreditation which is of an internationally acceptable standard, subject themselves to continuous review and meet specific criteria as set by a national entity. This should include issues of equity and access to participants so that no market segmentation is unfairly disadvantaged by the commercial considerations of individual operators. The quality of surveyor competency, training and ongoing contracting should also be a part of such arbitration.

4.10 Information assessment bodies will be required to provide to the National Entity on assessment outcomes against the national minimum safety assurance standards;

QIP/AGPAL believes this would be important in contributing to the national data set to assist with (1) ongoing standards development and (2) public confidence and accountability in the quality of a national safe and quality health care system.

4.11 Timeframes for the development and implementation of national minimum safety assurance standards; and

4.12 Resource implication of these changes and funding options that should be considered.

We feel unable to comment on these considerations until the scope of the work has been determined.

5. Assessment of non-clinical and technical compliance

Proposal:

The alternative model recognises that health services will continue to be required to comply and be assessed against jurisdictional regulation. Non-clinical and technical compliance standards will need to be identified and mechanisms developed to ensure recognition of these processes as part of a broader mutual recognition of accreditation which reduces duplication.

QIP/AGPAL Response:

Duplication and co-existing burdens of accreditation should be avoided against through mutual recognition.

Basis for Response:

5.1 The appropriateness and effectiveness of assessing separately non-clinical and technical compliance of a health service;

Except when jurisdictional regulation demands it, compliances which concern safety should be integrated, including non-clinical and technical compliance. This would guard against unnecessary administration burden which adds cost to service participation as well as streamline participation through a robust and transferable set of standards to underpin health services nationally

5.2 Timeframe for the identification of non-clinical and technical compliance requirements; and

5.3 The resource implication of these changes, if any and funding options that should be considered.

We feel unable to comment on these considerations until the scope of the work has been determined.

6. Development of a national framework for quality improvement

Proposal:

The alternative model proposes that a national quality improvement framework be developed for endorsement by Health Ministers and implementation by health services.

QIP/AGPAL Response:

Depending on what such a model intrinsically proposes, QIP/AGPAL is support for the principle of a quality improvement framework implemented across all health services.

Basis for Response:

6.1 The structure and content of a quality improvement framework;

6.2 International or local examples of a quality framework that could be considered in the development of an Australian quality improvement framework;

Referring back to the first question, a quality framework, against which standards act as a conduit towards improvement should be central to the modeling for accreditation reform. To this end, QIP/AGPAL supports that a quality framework should govern decision making around the type of standards/accreditation/improvement activity across health care disciplines in Australia as a whole.

QIP/AGPAL has its own framework within which accreditation, education, self directed assessment and quality plans occur. This is not unlike other accreditation and improvement organisations. It may be appropriate to share those which currently exist in the current context to identify synergies as a basis for moving forward. The risk, if this is not undertaken, is that there will be duplication and a proliferation of quality frameworks at various levels – rather than looking at some consistency that links safety standards and quality practice.

6.3 Timeframe for the development and implementation of a national framework for quality improvement;

6.4 The impact of these reforms on the accreditation service industry and their capacity to make the proposed changes;

6.5 Implementation issues that may arise; and

6.6 The resource implications for development of, and compliance with, a national quality framework and funding options available.

We feel unable to respond to these questions when the quality improvement framework is not yet defined

7. Establishment of a National Entity to lead and coordinate changes

Proposal:

The alternative model proposes that a National Entity be established to provide coordination and leadership of accreditation nationally. The National Entity will report to

1. Health Ministers;
2. industry;
3. community; and
4. the Australian Commission on Safety and Quality in Health Care in relation to safety and quality matters.

It will manage the processes of standards development, assessment of safety assurance, monitoring and reporting.

QIP/AGPAL Response:

We agree in part with the concept of a national coordination and stewardship body. However, we disagree with the scope of its management as proposed.

Basis for Response:

7.1 Options for the establishment of a National Entity

The general concept of a coordination body is supported in relation to the quality and standards framework. However, should another new body control monitoring and reporting and assessment then what hand would the profession have in leadership over their engagement in quality improvement? The key roles of such a body is to take the recommendations emanating from the national consultation to the next level and answer the more difficult questions regarding resourcing and funding, and review the infrastructure requirements intrinsic to the achievement of these aims. However, to impose another layer of compliance on professions which are already actively engaged in both leadership and governance roles is to undermine those groups which have recognized the importance of safe and quality practice to date. The preferred model is for the national entity to provide stewardship over the requirements and to coordinate the implementation process. For such a process to be truly successful there needs to be learnings derived from the many successful initiatives from primary to tertiary sector to date to act as a platform on which further development occurs. There must be a clear separation of the notion of "judge" and "jury" for participating services.

7.2 Mechanisms for ensuring stakeholder representation, particularly consumers;

Representation needs to derive from professionals, policy makers (including funders) and consumers.

7.3 The resource implication of establishing a National Entity and funding options that should be considered.

We feel unable to respond to this question when the national entity is not yet defined.

8. Review of surveyor training

Proposal:

The alternative model proposes that there be a review of surveyor training and assessment across the range of accreditation programs.

QIP/AGPAL Response:

We are supportive of a review and parameters established for surveyor training providing that there is tangible support and resource allocation to allow this to occur.

Basis for Response:

8.1 The priority of carrying out such a review;

This is an important issue but second, perhaps, to the establishment in the first instance of an overall quality framework to bind all health services against standards to improve safe and quality practice. Any changes in the requirements imposed regarding surveyor training will pose implications in relation to cost to the provider and participating practices. There needs to be clearer guidelines on surveyor training and an enforcement to ensure all providers commit to developing their surveyor workforce as a fundamental part of the quality framework and in a similar manner.

Managing and training surveyors is a large cost to the accreditation provider. In a commercial world there is inconsistency with how this is dealt with.

8.2 The scope of the review of surveyor training and assessment;

The scope must involve performance review as well as training and establishment of minimum expectations to be applied across the board. The issue of consistency is broader than training alone. A complete framework of managing surveyor performance is needed. That must include (i) recruitment – to attract the right people (not only interested or available people) (ii) performance review (to ensure optimal performers and (iii) training (to ensure consistency and ongoing professional development).

Training can involve common areas such as communication and then the technical part of the standards. The national entity might look at supporting common areas for surveyor training to share knowledge across industry and help reduce duplication of the number of training programs.

There are already international standards in place against which surveyor training can be assessed and these should be used as the basis for application by all providers.

8.3 The timeframe for the review; and

8.4 The resource implication of this review.

We do not feel able to comment on these when the scope of the proposal is not yet defined.

9. Associated Reforms

Proposal:

In addition to the changes in the alternative model there are a number of reforms that could be progressed as part of the implementation of broader reforms or as separate projects, as described above. These include:

- using unannounced surveys to assess the national minimum safety standards, (after appropriate piloting);
- piloting tracer methodology (patient journey);
- developing a best practice guide to standards development and review;
- mapping of standards;
- developing appropriate mechanisms, timing and format for public reporting; and
- developing a process for mutual recognition of accreditation processes and outcomes.

QIP/AGPAL Response:

We believe the most significant of these is (1) mutual recognition of processes and outcomes across healthcare dimensions to reduce duplication and service burden and (2) the concept of unannounced surveys if (a) such an approach offers more efficient and effective visits to assist in containing costs of accreditation participation and (2) it assists to position safety and quality as an ongoing and continuous process for health practice.

Basis for Response:

9.1 The priority of carrying out each of the proposals;
9.2 The scope of each of the proposals;

See above

To make this overall change to quality requires a multi-pronged approach. The framework for how and when practices are assessed against the standards is one part of the approach and any change to the existing model would have to be evidence-based and endorsed by the profession. As the leading provider of accreditation to general practices and other primary care disciplines, and governed by the profession, QIP/AGPAL would only support unannounced survey visits if many other broad and some complex factors in the accreditation process were considered, including the profession's viewpoint on this.

Significantly the process must accompany a broader decision about mandated accreditation participation; else unannounced visits might easily be perceived as a negative incentive towards engagement of health services. Of course, the model must be endorsed by the profession and be appropriately mandated to ensure equitable and consistent assessment and accreditation for any practice, regardless of the provider they are assessed by.

If unannounced visits were introduced the process must be integrated with the existing cycle of accreditation. Meaning, it must not add another layer of administration or be an extra visit. The process must enable a practice to self-assess against the standards and then make quality improvements to ensure a process of continuous quality improvement.

We might further support unannounced visits if the process was used to incentivise accreditation by recognising high performing practices. Potentially, high performing practices could have fewer unannounced surveys over time and poor performers be subject to more periodic surveys, ensuring those practices that strive towards best practice are rewarded.

Overall it is important that the model does not burden the existing process and encourages self assessment and improvement as these are the key aspects that accreditation is focused on. It must have some level of flexibility to account for the different types of practice and service types. Naturally, any change to the model of accreditation delivery must be financially sustainable for both accreditation provider and the participating health service.

9.3 The timeframe for the implementation of each of the proposals; and
9.4 The resource implication of the proposals.

We feel unable to comment on these considerations until the scope of the work has been determined.

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