

CONSULTATION PAPER

AN ALTERNATIVE MODEL FOR
SAFETY AND QUALITY
ACCREDITATION OF HEALTH CARE

This Consultation Paper has been prepared by the Commission as a basis for further discussion with stakeholders. Consultation is a key part of testing the proposed changes to the accreditation system for the safety and quality of health services in Australia. This stage of the consultations will be completed by December 2007.

The Consultation Paper proposes a new approach to accreditation and is designed to stimulate debate, and seek feedback and suggestions on a way forward.

This is a consultation document only, and the alternative model that it contains has not been endorsed by Commission members, Health Ministers or state and territory health authorities.

AUGUST 2007

Acknowledgement

During phase one of the National Safety and Quality Accreditation Standards Review over four hundred focus group participants and eighty eight individuals and organisations provided comment on the November 2006 Discussion Paper. A group of informed experts also reviewed the outcomes of the first phase of consultation. The proposed changes to the accreditation system detailed in this document have been shaped by this input. The involvement and willingness of all concerned to share their experience is much appreciated.

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Written submissions marked “National Safety and Quality Accreditation Standards Review” can be forward to:

GPO Box 5480
SYDNEY NSW 2001

Or via email to:

mail@safetyandquality.gov.au

NOTE

All written submissions must be received by **COB 5 October 2007** to be considered as part of the review.

All written submissions will be published on the ACSQHC website, including the names of individuals and /or organisation making the submission. The Commission will consider requests to withhold part or all of the contents of any submissions made.

INTRODUCTION

This Consultation Paper proposes an alternative model for accreditation of the safety and quality of health services in Australia. It is in response to a request by Health Ministers to review the current system and recommend a revised model for accreditation. The model includes development of national minimum safety standards and applies across all sectors of the health system in which registered health professionals practise, including private and public sectors providing institutional, ambulatory or primary care.

In July 2007 the model was presented to Health Ministers who endorsed it as the basis for further stakeholder consultation.

BACKGROUND

Paterson report

The Review of National Arrangements for Safety and Quality of Health Care in Australia (the Paterson report)¹ called for an alternative model of health service accreditation. It proposed that "...Ministers be provided with a plan to transform accreditation arrangements to enhance the role of accreditation in both quality improvement and in the implementation of agreed national standards". Health Ministers endorsed the outcomes of the Paterson report in July 2005.

AHMAC/AHMC brief

In June 2006, building on the Paterson report's recommendation, the Australian Health Ministers' Advisory Council (AHMAC) recommended to the Australian Health Ministers Conference (AHMC) that the Australian Commission on Safety and Quality in Health Care (the Commission):

- a. Review accreditation arrangements in Australia: consider these arrangements in light of international experiences and recommend a revised model for accreditation of health services both public and private across Australia;
- b. Provide a Discussion Paper to AHMC by October 2006, outlining the strengths and weaknesses of the current system, the benefits that can be gained in a future system and a process and timetable for recommending an alternative model for accreditation including a national set of standards by which health services would be assessed; and
- c. Provide a draft report to AHMC by June 2007 and a final report by December 2007.

In November 2006, AHMC agreed to these recommendations and approved the public release of the Commission's Discussion Paper – *National Safety and Quality Accreditation Standards* (the Discussion Paper) for consultation.

In July 2007, findings from the initial stakeholder consultation process and an alternative model were considered by Health Ministers. They noted the proposals and agreed that the alternative model form the basis for phase two discussions with stakeholders on revising current safety and quality accreditation in the Australian health care system.

¹ AHMC (2005) National Arrangements for Safety and Quality of Health Care in Australia: the report of the review of future of future governance arrangements for safety and quality in health care.

Overview of consultation process

Phase one of consultation commenced with the release of the Discussion Paper in November 2006. Discussion Paper consultation involved preliminary stakeholder meetings, focus groups, written submissions and review of outcomes by an expert group. Phase one concluded with the presentation of the Interim Stakeholder Consultation Report and draft recommendations for changing the accreditation system to Health Ministers in July 2007.

Phase two commences with the release of this Consultation Paper. It will involve consultation on the alternative model and its proposed changes.

A final report, with recommendations for reform of the accreditation system, including an implementation plan, will be forwarded to Health Ministers by March 2008.

Processes for phase two stakeholder consultation: A call for written submissions on the Consultation Paper

Written submissions are invited from stakeholders on the alternative model and changes proposed in this Consultation Paper. Stakeholders are invited to provide comment on the proposed alternative model and its implementation.

Submissions received by the Commission up to the close of business on 5 October 2007 will be considered as part of the review process. All submissions will be published on the Commission's website, and include the name(s) of individuals and or organisations making submissions. The Commission will consider requests to keep confidential part or all of the contents of any submission.

PHASE ONE STAKEHOLDER PERSPECTIVES

The report on phase one of the consultation process “*Report on Initial Stakeholder Consultation: Review of National Safety and Quality Accreditation Standards*” is on the Commission’s website www.safetyandquality.gov.au. This report provides detailed information on stakeholder concerns with the current accreditation system and reasons for their support, or otherwise, for changing the accreditation system.

There was significant stakeholder engagement in phase one of the review process and a high level of concern about current accreditation arrangements, which was evidenced by:

- the number of stakeholders self-nominating for focus groups nationally – over 530 individuals
- the number of stakeholders participating – over 404 in 40 focus groups nationally and 88 written submissions received by the Commission
- the willingness of stakeholders to debate issues and reforms, and
- the stakeholder response in focus groups when invited to provide comment on the importance of the issues raised in the Discussion Paper – of the 351 respondents, 21% rated the issue of accreditation reform as critical and 69% rated the issue as significant.

Support for Reform

Representatives from organisations engaged in the accreditation system were generally supportive of reforming accreditation processes. This is evidenced in the written submissions of which only 3 out of 88 argued for a continuation of the current system, 14 provided overall support for reform, and the remaining 60 identified strategies, opportunities and/or barriers for reform.

The private hospital sector expressed concern that reform would offer few benefits if it does not simplify and streamline the overall safety and quality compliance burden. That burden includes accreditation requirements, unharmonised state and territory licensing requirements and the extent and detail of private health insurance safety and quality reporting.

Opposition to Reform

Support for reform was not, however, unanimous. There was little or no support for reform from two key groups. Firstly, there was limited support from those organisations that do not currently participate in an accreditation system for services such as dental practices, specialist medical practices and allied health private practices. These groups sought evidence for the effectiveness of accreditation before it was introduced more widely. Secondly, there was little support from ISO 9001 accreditation certifying bodies which reported that the ISO system worked well.

Reasons for reform

Stakeholders identified a range of reasons for reform, which have been grouped under three key headings. They were:

Confusion in the current accreditation system

1. There is no consensus about the purpose of accreditation, and its role in the health system is not clear.
2. The current accreditation processes merge both safety assurance and quality improvement into processes, standards and recommendations which compromise achieving either aim.
3. The accreditation system is currently characterised by fragmentation, lack of coordination and an absence of integration.

Value of the current accreditation system

4. A shift in the focus of accreditation from peer review and supported quality improvement to more emphasis on inspection and regulation has devalued accreditation for some stakeholders.
5. There is a growing compliance burden associated with safety and quality and there are multiple accreditation processes with significant overlap and duplication.
6. Existing accreditation programs have limited or no scope to be tailored to an organisation's own risk assessment and individual safety and quality improvement needs.
7. There is a proliferation of standards with safety and quality components, but no process to identify those which are essential to achieving safety and quality outcomes.
8. Existing accreditation requirements are often considered to be entry level / minimal safety and quality standards.

Accountabilities in the current accreditation system

9. There are gaps in accreditation coverage with some settings of health care that are not currently accredited increasing and in some instances providing high risk services.
10. There is an absence of minimum safety standards across all settings of care, despite a high level of consumer expectation.
11. The current accreditation system does not sufficiently focus on consumers.
12. The level of confidence in the rigour and robustness of survey processes and the reliability of accreditation outcomes is declining.
13. There is a potential or perceived conflict of interest involved in the same bodies developing, owning and assessing compliance against accreditation standards.
14. There is no mechanism for linking accreditation to national safety and quality priorities.
15. Ministers are held accountable by the community for the safety of the health system, but have no formal mechanism to influence the accreditation process and the standards that apply.

Reform objectives

Where reform was supported, stakeholders saw the following reform objectives as important. Reforms should:

- Simplify confusion and complexity;
- Clarify the role of government in safety assurance and safety regulation;
- Create a system that guarantees minimum safety of health services;

- Create an environment in which quality improvement processes, language, format and definitions of safety and quality standards can move toward harmonisation and standardisation;
- Create flexible and cost efficient assessment programs that meet the local needs of health services;
- Provide greater clarity about process, results and accountability for consumers, providers and funders;
- Use existing organisations, funding models and structures in preference to establishing new ones;
- Ensure accreditation delivers maximum value (appropriate, effective and efficient) for money; and
- Build on the positive components of the current accreditation system outlined in the report on the first phase of consultation.

Other principles of key importance were that:

- The public interest in safe, quality health care is paramount;
- Sound governance and regulatory principles are essential; and
- Achieving national efficiency and effectiveness of accreditation as a safety and quality tool is a priority.

Further, while some stakeholders consider that continuation of the current accreditation system is possible, stakeholders contest whether this is practical, sustainable or good value for the health system. It is essential that the advantages and benefits of existing systems be retained in any alternative model and that compliance burden and costs not increase.

In developing a new model for accreditation, the Commission recognises that accreditation is only one tool that organisations will use to achieve safety and quality outcomes. An accreditation process cannot be the sole guarantee of safety. However, accreditation should provide a base to support and enhance other safety and quality initiatives, whether at the national or organisational level.

Development of reform proposals

The Discussion Paper, which was used as the basis of stakeholder consultation in phase one of the review, proposed a number of primarily operational reforms. These included:

- the introduction of new methodologies into the accreditation process;
- the establishment of two registers, one to register accrediting bodies, the other to register standards used to assess safety and quality; and
- mapping standards and harmonising of language and definitions used in accreditation.

Stakeholder responses to these proposals have been taken into consideration in developing the alternative model. A summary of the Discussion Paper proposals and their fit with the alternative model is at Attachment 1.

The alternative model has evolved from the options and solutions identified by stakeholders to address issues with the current system. It takes into account recommendations for strategic reform and seeks to address Ministerial concerns with the lack of national coordination of standards development and accreditation. However, the alternative model presented in this

Consultation Paper primarily recommends high level strategic reforms of the accreditation system together with only a few associated operational reforms.

The alternative model provides a more detailed proposal on future reform than the Discussion Paper proposals, but still recognises that significant stakeholder input is required to refine and finalise any proposals for reform.

Matters excluded from reform proposals

The alternative model cannot address all aspects of duplication in reporting and safety and quality compliance for both public and private health services. In particular, requirements relating to state and territory licensing, and safety and quality reporting mandated by health funds, indemnity insurers and program funding are not included in this review process. Accordingly, these requirements are likely to continue or may increase unless relevant organisations agree that the national minimum safety standards and quality improvement framework meet their needs and that additional measures are unnecessary. The Commission is interested in promoting this outcome to the greatest extent possible. This issue will be considered as part of a separate process during phase two of stakeholder consultation.

To reduce duplication, the Commission seeks to maintain existing mutual recognition arrangements between accreditation and regulatory or funding requirements, such as the recognition of RCPA/NATA accreditation.

The alternative model does not address accreditation of health services provided by non-registered health professionals. As the criteria for registration relates to potential consumer harm, higher risk services provided by registered practitioners are the focus of the proposal. Although a number of stakeholders called for an expansion of the terms of reference for accreditation (such as reform proposals addressing other human services like Home and Community Care, aged care, and disability services), the terms of reference for this review are limited to accreditation of health services. However, the work undertaken in this review may be a useful reference point for these other services.

As the standards and the accreditation processes of aged care facilities sits within a legislative framework they are specifically excluded from this review, although some of the changes proposed may have flow on effects in that sector.

AN ALTERNATIVE MODEL FOR THE AUSTRALIAN ACCREDITATION SYSTEM

The alternative model clarifies the purpose of accreditation and supports the development and use of appropriate and effective assessment methodologies and standards. A diagram of the alternative model is at Figure 1.

It is recognised that accreditation of health services will remain a key strategy to maximise patient safety and quality care. However, the alternative model represents a substantial reform of the accreditation system that aims to reorientate relationships between existing bodies and provide greater accountability and clarity. In addition, the national minimum safety standards framework and the quality improvement framework must strongly focus on consumers.

To effectively implement, the alternative model requires broad stakeholder support, the introduction of regulatory mechanisms for mandating national minimum safety standards and industry cooperation to provide flexible quality improvement products and services.

Key elements of the alternative model

1. Separation of safety assurance and quality improvement assessment processes

The proposal

The alternative model proposes separating the setting of safety standards and processes to measure safe delivery of care from quality standards setting and assessment processes. This is intended to improve the ability of accreditation to assure safety and productively promote quality improvement.

The aim of a separate safety assurance process is to provide greater clarity on:

- the purpose of safety assurance accreditation;
- the requirements to support safe service delivery; and
- what consumers and other stakeholders can reasonably expect of an accredited health service.

The aim of the proposed changes to quality improvement processes is to:

- ensure that health services continue to invest in quality improvement;
- provide choice that better meets the quality improvement needs of organisations and their consumers;
- ensure that investment in quality improvement is consistent with the priorities and targets established by an agreed national framework and is appropriate to the service type; and
- provide a framework that guides the many different activities which constitute quality improvement.

Why?

Stakeholders have a range of perspectives on the purpose of accreditation. Accreditation was described as a mechanism for:

- detecting poor performance;
- ensuring accountability;

- promoting best practice;
- facilitating continuous quality improvement and organisational learning;
- managing risk; and / or
- ensuring compliance with minimum standards.

It was apparent that standards and accreditation processes are increasingly used as a solution to a wide range of safety and quality issues facing the health care system. Accreditation has shifted from being a primarily voluntary system to an integral part of access to funding, licensing and meeting accountability requirements of governments. This confusion of purpose makes it difficult for the community and consumers to understand or form reasonable expectations of what an accredited service can and should deliver. Stakeholders also reported that evidence was generally available to support the development of and assessment against safety standards, while quality was much more subjective and therefore more difficult to measure.

Currently, processes for ensuring the safe delivery of a service and measuring the gains in quality are combined in the accreditation process. Stakeholders report this has led to uncertainty about the role that surveyors play, whether they act as inspectors testing processes and systems to ensure safe delivery of care or as peers sharing ideas and information to encourage quality gains. Surveyor training does not appear to have clarified the role.

What does this mean for Stakeholders?

For health service providers currently accredited:

Health services will be required to comply with, and report on, national minimum safety standards. They will also be required to have in place a program that is consistent with an agreed national framework for quality improvement (see page 16).

For health service providers not currently accredited:

Like accredited health services, non-accredited services will be required to comply with, and report on, national minimum safety standards. Once assessment against national minimum safety standards is fully established, they will also be required to implement quality improvement programs that comply with the national framework for quality improvement.

For consumers:

Consumers can be confident that safety assurance accreditation means services have met minimum safety standards. They will have access to minimum safety standards and guaranteed information about accreditation against the standards.

For standards setting bodies:

Standard setting bodies will develop and maintain quality improvement standards. Standards setting bodies will not set national minimum safety standards but may be involved in development of them.

For accrediting bodies:

Accreditation bodies may choose to undertake any of the following roles in the system:

- assessing compliance against safety standards;
- assessing quality improvement on behalf of a health service; or
- assessing both safety assurance and quality improvement for a health service.

For regulators:

Legislative or regulative mechanisms may ensure compliance with national minimum safety standards and the application of the national framework for quality improvement.

For funders:

Funders may consider payment incentives for compliance with safety standards and quality improvement standards and sanctions for not doing so. For example, failure to comply with safety assurance may mean funding or service suspension.

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

The proposal

The alternative model proposes an absolute separation of safety standards development and accreditation assessment of health services. A national body will be responsible for developing safety standards that are endorsed by Health Ministers. The safety standards will operate within a national minimum safety standards framework.

A mechanism for recognising bodies to assess against the national minimum safety standards will be established by a national body. Only assessment bodies that are recognised will be eligible to assess against the national minimum safety standards. Assessment bodies will be required to provide information on assessment outcomes against the national minimum safety standards to a national body.

Why?

Five state/territory health departments addressed the issue of separation of standards setting and accreditation assessment in phase one. All called for a separation of these responsibilities. They noted there is greater potential for conflict of interest when these functions are co-located, and that separation is required for good governance, and removal of actual or implied conflicts of interest.

In addition, stakeholders reported that when separate bodies perform both the standards setting and accreditation assessment roles, there is a potential for a proliferation of standards and greater variability of processes. These are barriers to national harmonisation of standards and consistency of processes. Stakeholders have suggested it is more appropriate to assess against national standards.

What does this mean for Stakeholders?

For health services that are currently accredited:

There is likely to be little impact from the separation of standards development and assessment services on health services that are currently accredited.

For health services not currently accredited:

There will be no impact from the separation of standards development and assessment services for these stakeholders on health services that are currently not accredited.

For consumers:

This proposal will improve consistency of safety for consumers. They will continue to be involved in standards development, standards setting bodies, the assessment of health services and directly with a national body.

For standards setting bodies:

Quality improvement standards will continue to be developed by standards setting bodies. Standards setting bodies may be involved in the development of national minimum safety standards, through contract arrangements or direct involvement with a national body. The national entity will develop quality improvement standards, but seek technical and service specific expertise (eg. from standards bodies, professional colleges, NHMRC) during development.

For accrediting bodies:

Accrediting bodies will continue to assess health services against standards developed by a range of bodies, including national minimum safety standards developed by a national body. There will be a need to structure accrediting bodies that also set quality improvement standards to ensure these functions are separate.

For regulators:

Regulators will have greater confidence in the rigour of assessments and the consistent application of safety standards across the health sector.

For funders:

Governments that have previously contributed to the development of safety standards through independent standards setting bodies may reconsider this investment. There is likely to be no impact from this proposal for other funding bodies.

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

The proposal

The alternative model proposes that health services provided by any registered health professional will need to comply with national minimum safety standards. If no accreditation requirements currently apply, then health services will initially comply only with the national minimum safety standards, with a staged introduction of quality improvement framework compliance to follow. This will ensure a process for safety assurance and monitoring exists for the vast majority of health services.²

² Reform of the accreditation of education and training of health professionals in health facilities is being conducted by the Council of Australian Governments. As with the reform proposal for safety and quality accreditation of health services, CoAG have recommended that the reform of the education and training of health professionals apply to registered health professionals, although the CoAG reforms initially limit changes to those professions registered in all states and territories.

Why?

Stakeholders generally agreed that some areas of health care which are not currently accredited, and where high risk services are provided with limited or no external assessment of safety, should be accredited. They have argued that the gaps in accreditation beyond the hospital sector represent an unacceptable risk to patients.

It is in the public interest that health professionals are registered as consumers assume registration is a guarantee of safety. Stakeholders generally agreed that public interest also requires that settings in which registered health professionals provide care should meet minimum safety standards. Criteria developed by AHMAC to determine which professional groups should be registered are primarily based on the capacity of the care provided by a health professional to cause harm to a patient. Individual states and territories have different approaches and as a result some allied health professions are registered in some states and territories but do not require registration in others. Nationally, there are twenty one professional groups that are registered in one or more state or territory. A list of the major health professional groups and their registration status is at attachment 2.

What does this mean for Stakeholders?

For health services that are currently accredited:

There is no impact from this proposal for health services that are currently accredited.

For health services not currently accredited:

The greatest impact from this proposal will be on services that are not currently accredited. These services will be required to implement an accreditation system. Where existing regulatory requirements are in place these are likely to be simplified and incorporated into the safety assessment processes. For services that operate in a low risk and non-complex environment the compliance burden will be minimal.

For consumers:

Services that provide health care that has the potential to harm will be assessed against national minimum safety standards, consistent with reasonable consumer expectations and entitlements.

For standards setting bodies:

It is likely that for services where standards do not exist, service specific standards may need to be developed. Some groups may wish to develop or collaborate on the development of these new standards. This could apply to services provided in rooms by doctors, dentists or allied health professionals.

For accrediting bodies:

There is the potential to provide new assessment services with an expansion of the number and categories of health services that will be required to comply with minimum safety standards and, over time, implement a quality improvement framework.

For regulators:

Regulators may need to consider incentives and sanctions to meet gaps that currently exist in health services accreditation by requiring all registered health professionals to accredit.

For funders:

Funders may wish to consider funding to support the implementation of accreditation in some non-accredited services, or for timely development of standards.

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

The proposal

The alternative model proposes endorsement by Health Ministers of national minimum safety standards developed within a national minimum safety standards development framework. Responsibility for national minimum safety standards development would rest with a national body (see point 6 below), that will ensure standards are:

- Measurable;
- informed by evidence;
- address major safety risks; and
- apply across all settings of care.

National minimum safety standards may include infection control/hygiene, credentialing/registration of practitioners, medication safety, patient identification and communication including handover and information transfer and privacy. National minimum safety standards will assure reasonable consumer expectations about the safety of health services. The national minimum safety standards will be mandatory with an assessment process that could result in sanctions or penalties if standards are not met.

All settings of care will be assessed against each national minimum safety standard. Each standard will cover a specific subject area. However, not all elements of each standard will be applicable across all settings of care. For example, infection control covers a broad range of practice activities but steriliser management will not be applicable in settings of care which do not operate a steriliser.

For safety assurance measures to be effective and efficient, the coverage of national minimum safety standards will be determined using clear criteria explicitly documenting why specific subject areas are included or excluded. A process of regular review, and a mechanism for removing standards if they become inappropriate or obsolete, will also be established. Each of these processes will be inclusive of, and transparent to, stakeholders. Key to maintaining the efficiency and effectiveness of safety assurance is the early development of processes to ensure safety standards over time remain current and only address key safety and quality issues where there is a compelling case for mandating compliance.

The alternative model anticipates that regulation will be required to mandate national minimum safety standards compliance. Suitable regulatory mechanisms have not been defined and require further consideration by Commonwealth, state and territory and governments as part of consultations on the alternative model.

Why?

In phase one, stakeholders recognised community expectations of health services to meet minimum safety standards and that the community will hold governments accountable when they do not. Currently, Health Ministers have no formal mechanism to influence the accreditation process, to review the outcome of accreditation assessments (as this information is generally not publicly available) and to influence the standards that are applied in the system.

What does this mean for Stakeholders?

For health services that are currently accredited:

Recognised accrediting bodies will assess health services against national minimum safety standards. Assessment methods may include external site inspections, desk top audit or regular data submission. Their role will be to assess compliance with national minimum safety standards, collect data, monitor and review variances. In addition, they will be required to review national feedback on minimum safety standards provided by the National Entity and act on this information, as appropriate.

For health services not currently accredited:

Recognised accrediting bodies will assess health services not currently accredited against national minimum safety standards. Assessment methods may include evaluation by external site inspections, desk top audit or regular data submission. Their role will be to assess compliance with national minimum safety standards, collect data, monitor and review variances. In addition, they will be required to review national feedback on minimum safety standards provided by the National Entity and act on this information, as appropriate.

For consumers:

Services that provide health care that has the potential to harm will be assessed against national minimum safety standards, consistent with reasonable consumer expectations and entitlements.

For standards setting bodies:

Standards setting bodies will no longer be responsible for setting national minimum safety standards. This will be the responsibility of a national body.

For accrediting bodies:

Recognised accrediting bodies will assess health services against minimum safety standards. Assessment methods may include evaluation by external site inspections, review of desk top audit or collating of submitted data.

For regulators:

Government will endorse a process for approving national minimum safety standards that are set by the National Entity in accordance with an agreed Ministerial process. Regulators will receive consolidated National Minimum Safety Standards reports.

For funders:

Minimum safety standards are an opportunity for funders to offer incentives and sanctions, where appropriate.

5. Assessment of non-clinical and technical compliance

The proposal

The alternative model recognises that health operates in a regulatory environment, and that states, territories and the Commonwealth will continue to require services to comply with jurisdictional regulation. The alternative model aims to prevent duplication of all safety assurance accreditation processes, including minimum safety standards, non-clinical regulation and technical compliance by a system of mutual recognition.

Why?

Stakeholders recognised the necessity and value of external assessment against a range of state based non-clinical regulations (eg fire safety, chemical storage, food safety) and specific technical accreditation processes (eg pathology, radiology assessment). They were concerned that any new model ensures that external assessments are recognised in other assessment processes and that there is no duplication of assessment, reporting or compliance effort.

What does this mean for Stakeholders?

For health services that are currently accredited:

Compliance requirements for health services with Commonwealth, state and territory regulation, such as licensing, fire and safe storage of chemicals and accreditation processes and pathology and radiology accreditation, will continue. However, compliance assessment will only occur once and be mutually recognised by other assessment processes.

For health services not currently accredited:

Compliance requirements for health services with Commonwealth, state and territory regulation, such as licensing, fire and safe storage of chemicals and accreditation processes and pathology and radiology accreditation, will continue. However, compliance assessment will only occur once and be mutually recognised by other assessment processes.

For consumers:

This proposal may benefit consumers by increasing, or enhancing, services through efficiency gains.

For standards setting bodies:

There is no impact from this proposal for standards setting bodies.

For accrediting bodies:

Accrediting bodies will require recognition by a national body to be eligible to undertake regulatory assessment. It is anticipated that some technical assessment bodies, such as NATA, will continue as the primary clinical compliance assessor in their specific areas.

For regulators:

There is little likely impact from this proposal for regulators.

For funders:

Compliance costs may be reduced for health services but these savings may not be easily realised.

6. Development of a national framework for quality improvement

The proposal

The alternative model proposes that a national body (see point 7 below) develop a national quality improvement framework for endorsement by Health Ministers. The aim of a national quality improvement framework is to:

- encourage and support quality improvement activities;
- identify opportunities for improvement and shared learning; and
- showcase exemplary practice.

Health services would continue to implement quality improvement programs locally, but within a broader quality improvement framework.

The quality improvement framework may include:

- priorities and targets or a quality action plan;
- ways of assessing and monitoring improvement internally against such a plan; and
- collection by a national body of high level and educative information about use of the national quality improvement framework.

Quality improvement standards which meet nationally agreed criteria for best practice and consumer focus will be endorsed as a way of moving towards consistent national quality standards.

Health services will continue to have a choice of accreditation providers but with greater flexibility on what, how and when they invest in quality improvement. Health services will have a role in selecting the appropriate quality improvement framework elements relevant to their organisational type and needs. Quality improvement modules could be offered by accrediting bodies, professional colleges, universities, etc. and/or developed internally in national, state or large organisations.

Why?

Participants in phase one of the consultation process noted the shift over time of accreditation from a focus on peer review and supported quality improvement to one of inspection and regulation. This may have had a negative effect on the way quality improvement is implemented and assessed. This is a concern because quality improvement remains a strategy used by health services to improve patient outcomes.

What does this mean for Stakeholders?

For health services that are currently accredited:

A quality improvement framework will not affect health services' current ability to choose accreditation providers. They will have greater flexibility on what, how and when they invest in quality improvement, and a role in selecting the appropriate quality improvement framework elements relevant to their organisational type and needs.

For health services not currently accredited:

Health services not currently accredited will ultimately be affected by this proposal but not for some time. Initially, health services not currently accredited will comply only with national minimum safety standards. Quality improvement framework compliance will be introduced in stages.

For consumers:

Health services will continue to improve guided by an evidence-based, national quality improvement framework.

For standards setting bodies:

Some standards setting bodies may need to shift the language and intent of their standards from pseudo-regulatory statements to a clear focus on quality improvement. This is likely to be a requirement for endorsement of standards by the national body.

For accrediting bodies:

As health services select the appropriate quality improvement framework elements relevant to their organisational type and needs, accrediting bodies will have the opportunity to develop a range of quality improvement products and services.

For regulators:

For regulators, the current accreditation system is unsatisfactory for managing quality improvement and ensuring patient safety. The alternative model trades a nationally consistent system of safety assurance (addressing key areas of concern for governments) for greater health services autonomy to improve quality according to local need.

For funders:

Because funders include governments, health insurers and other third party payers, including patients, there are differences in safety and quality priorities. This may mean that funders will require different levels of quality compliance. If this variation is excessive, it will potentially add costs and inefficiency to the alternative model.

7. Establishment of a national body to lead and coordinate changes

The proposal

The alternative model proposes that a national body be established (a National Entity) that can provide national coordination and leadership. It will be responsible for:

- a. developing a national minimum safety standards framework and process to be endorsed by Ministers;
- b. developing national minimum safety standards informed by clinical outcomes that focus on high risk safety areas;
- c. monitoring progress against the national minimum safety standards;
- d. recognising bodies to assess against the national minimum safety standards and some other technical and regulatory standards;
- e. endorsing quality improvement standards where they meet nationally agreed criteria for best practice and consumer focus, as a way of moving towards consistent national quality standards;
- f. developing guidelines for public reporting against both national minimum safety standards and the national quality improvement framework; and
- g. providing a mechanism for the independent assessment of accreditation decisions, assigning accreditation status and appeals.

Why?

Although accreditation is a requirement across much of the health sector, there is little or no national coordination of processes, data or analysis of accreditation outcomes. Stakeholders have raised concerns about duplication and overlap of standards and accreditation effort.

What does this mean for Stakeholders?

For health services that are currently accredited:

The National Entity will provide health services with comparative data on safety measures that could be used for benchmarking. It will allow health services to appeal accreditation decisions. Duplication of assessment will be reduced by mutual recognition of assessment processes across technical and other regulatory standards bodies. Health services will have access to both national minimum safety standards and endorsed quality improvement standards and a framework for quality improvement.

For health services not currently accredited:

The National Entity will allow health services to appeal accreditation decisions. It will provide health services with comparative data on safety measures that could be used for benchmarking. Duplication of assessment will be reduced by mutual recognition of assessment processes across technical and other regulatory standards bodies.

For consumers:

Consumers can be confident that accreditation means services have met minimum safety standards. They will have access to the national minimum safety standards and compliance information.

For standards setting bodies:

Standards setting bodies will apply to the National Entity for endorsement of their quality standards.

For accrediting bodies:

Accrediting bodies will be recognised by the National Entity as assessors and will provide information collected during assessment to the National Entity.

For regulators:

Information on national trends in safety and quality improvement will be available to regulators for use in policy and decision making. Through the National Entity, regulators will be able to directly influence the national minimum safety standards.

For funders:

Information on national trends in safety and quality improvement will be available to funders for use in policy and resource allocation.

8. Review of surveyor training

The proposal

The alternative model recognises the importance of surveyors in the assessment of safety and quality standards. It recommends a review of training, skills and surveyor competency across a range of accreditation programs. The review will propose ways to improve surveyor competency and inter-assessor reliability. This could result in minimum surveyor requirements or a recommended structure for the training and support of surveyors.

The Commission is seeking further stakeholder input on this proposal with regard to its:

- Priority for undertaking this review;
- Scope;
- Timeframe; and
- Resource implication.

Why?

Stakeholders raised a range of issues about the effectiveness of surveyor training and competency assessment and opportunities for improving it. Stakeholders recognised the importance of surveyors in the current accreditation system and the need to ensure sustainability of this workforce.

9. Associated Reforms

The November 2006 Discussion Paper proposed a range of other reforms. Phase one stakeholder consultation found support for some of these reforms, and a more cautious reaction to other reforms, with suggestions for pilots before wider application.

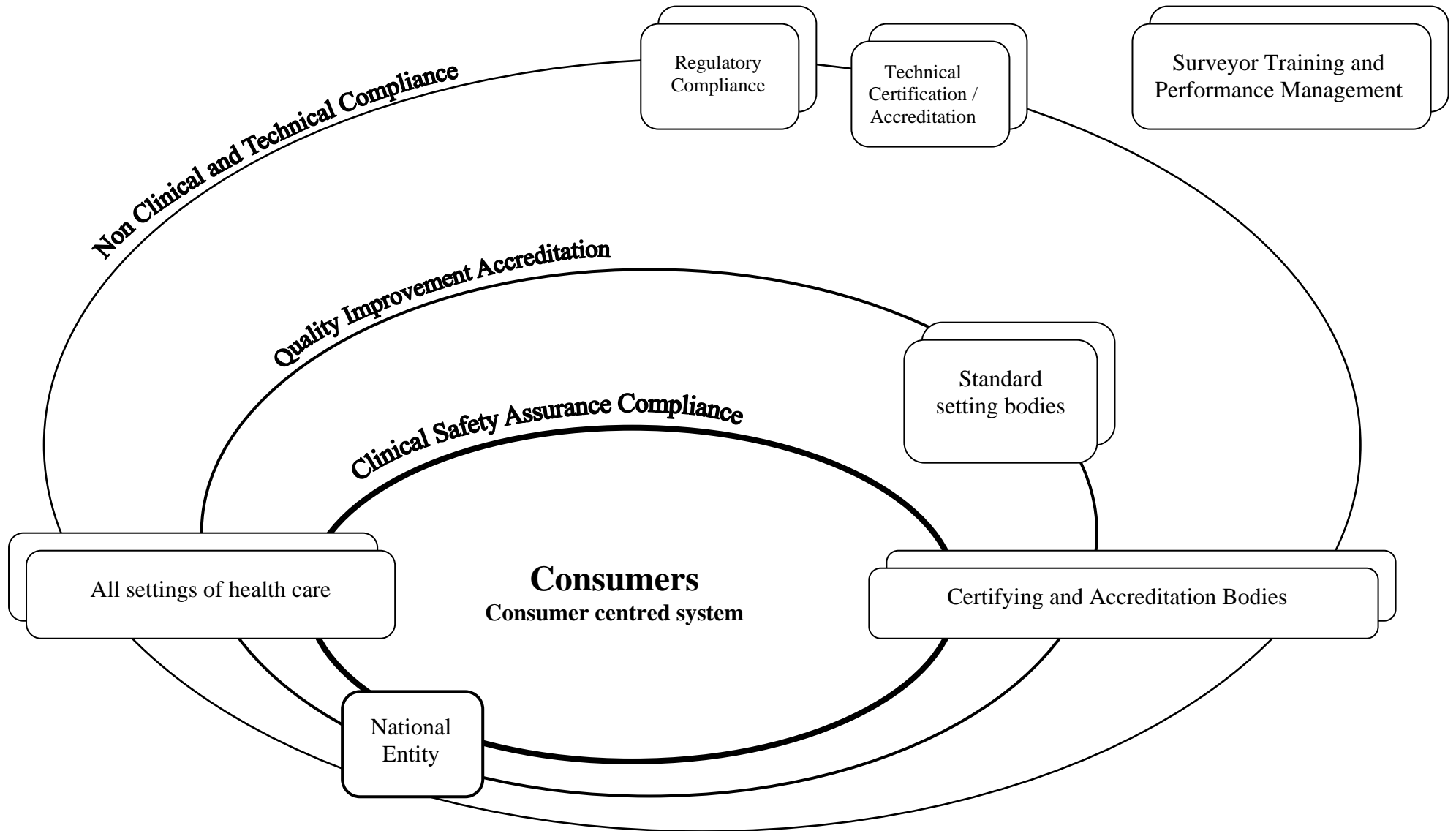
Other process reforms that could progress parallel to implementation of the alternative model, or as separate projects, include:

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

The Commission is seeking further stakeholder input on each of these proposals with regard to their:

- Relative priority;
- Scope;
- Timeframe; and
- Resource implication.

Figure 1: Alternative model for Safety and Quality Compliance and Accreditation



Legend:

All settings of health care - all locations of care where a health service is provided by a registered health professional. This will include institutional care, primary, specialist and community care in both the public and private sectors. It expands the current coverage of accreditation for minimum national safety standards to encompass private practices in rooms, dental practices and Aboriginal Medical Services.

Regulatory Compliance –all non-clinical compliance required by state, territory or commonwealth governments, specified in legislation, regulation or policy. This is a continuation of existing compliance requirements. These requirements are generally mandatory minimum safety requirements that ensure a safe environment in which services can be provided and include fire safety, storage of hazardous chemicals and food safety.

Technical Certification / Accreditation– assessment and compliance processes associated with technically specific standards that are generally mandated by governments that exist for accountability purposes as well as for the safety and quality of patients. This is a continuation of existing compliance requirements. They include programs such as NATA assessment of radiology, pathology and nuclear medicine, Breast Screen Australia and the Therapeutic Goods Administration.

Certifying and Accrediting Bodies – organisations and bodies that assess health services compliance with safety and/or quality standards. They could be:

- recognised by the National Entity as eligible to assess against national minimum safety standards and regulatory compliance. These bodies will assess against quality improvement standards;
- not recognised by the National Entity and will provide quality improvement services only; and / or
- recognised by the National Entity as a provider of technical assessment services.

The alternative model proposals will result in changes to the reporting requirements of certifying and accreditation bodies, health services and the National Entity.

Standards Setting Bodies – standards setting and professional bodies, disease specific interest groups and government and other committees that develop safety and quality standards. Some of these standards are used for accreditation. The alternative model proposes that these bodies continue to develop standards. However, the process of standards development and the resulting standards may vary from those currently being used.

National Entity – a new entity that would have primary responsibility for the leadership and coordination of accreditation activity across all the health system. This body would ultimately report to Health Ministers. Its functions and structure are discussed elsewhere in this paper.

Clinical Safety Assurance Compliance – a process for ensuring that health services provided by a registered health professional comply with national minimum safety standards for patient care.

Quality Improvement Accreditation – the processes employed by health services to ensure quality improvement of services and compliance with the national quality improvement framework.

OPTIONS FOR THE IMPLEMENTATION OF THE ALTERNATIVE MODEL

The Commission is seeking stakeholder input on the alternative model, its components and the associated reform proposals in section 9 above. The Commission is interested in feedback on implementation issues generally and the issues raised below in relation to each proposal specifically.

1. Separation of safety assurance and quality improvement assessment processes

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.

The Commission is seeking stakeholder input on:

- The appropriateness and effectiveness of separating safety assurance and quality improvement;
- Timeframes for the implementation of a separation of safety assurance and quality improvement; and
- The resource implications of this change and funding options that should be considered.

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

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

The Commission is seeking stakeholder input on:

- The mechanism for achieving this change
- Timeframe for the implementation
- The resource implication of these changes and funding options that should be considered

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

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.

The Commission is seeking stakeholder input on:

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

- Transition arrangements required to implement the assessment of national minimum safety standards in all settings of care;
- A prioritisation process for the staged implementation of changes for services that are not currently accredited;
- Timeframes for the implementation of safety assessment processes;
- The resource implication of these changes and funding options that should be considered; and
- Incentives that could be considered

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

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.

The Commission is seeking stakeholder input on:

- The criteria and processes for determining national minimum safety standards. For example, the National Entity could develop standards directly (using working groups of technical experts, consumers and other stakeholders) or it could outsource to an appropriate body or collaborative;
- The areas to be addressed by the standards and the coverage of each standard;
- The priority order for the development of standards, which may be risk-based;
- Whether the assessment outcome against minimum safety standards should be pass or fail
- What a failure would mean for a health service;
- Under what circumstances a 'fail' rating would be applied;
- Sanctions or penalties that would result;
- Mechanisms to ensure mandatory compliance against national minimum safety standards. Detailed consultation with jurisdictions on how to most effectively implement mandatory compliance will be undertaken by the Commission;
- Options for assessing national minimum safety standards and mechanisms to reduce the subjectivity of the outcome and inter-assessor reliability. For example, they may be suited to assessment through desk top audit and complemented by unannounced surveys;
- Mechanisms to recognise bodies to assess against national minimum safety standards. For example, the approval process could include agreement by the assessing body to provide assessment information to the national entity and for them to be externally accredited by independent bodies such as ISQUA and JASANZ. There may also be specific requirements about the training, competence assessment, performance management, experience and reliability of assessors;
- Information assessment bodies will be required to provide to the National Entity on assessment outcomes against the national minimum safety assurance standards;
- Timeframes for the development and implementation of national minimum safety assurance standards; and
- Resource implication of these changes and funding options that should be considered.

5. Assessment of non-clinical and technical compliance

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.

The Commission is seeking stakeholder input on:

- The appropriateness and effectiveness of assessing separately non-clinical and technical compliance of a health service;
- Timeframe for the identification of non-clinical and technical compliance requirements; and
- The resource implication of these changes, if any and funding options that should be considered.

6. Development of a national framework for quality improvement

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

The Commission is seeking stakeholder input on:

- The structure and content of a quality improvement framework;
- International or local examples of a quality framework that could be considered in the development of an Australian quality improvement framework;
- Timeframe for the development and implementation of a national framework for quality improvement;
- The impact of these reforms on the accreditation service industry and their capacity to make the proposed changes;
- Implementation issues that may arise; and
- The resource implications for development of, and compliance with, a national quality framework and funding options available.

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

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.

The Commission is seeking stakeholder input on:

- Issues that may arise in the establishment of a National Entity;
- Options for the establishment of a National Entity. For example, whether it should be establishment within an existing body, as a secretariat, or by the creation of a new body. The National Entity could operate as a statutory body, an incorporated body or as an advisory body in the way the Australian Commission on Safety and Quality in Health Care (the Commission) operates;
- Mechanisms for ensuring stakeholder representation, particularly consumers;
- Timeframe for the establishment of a National Entity; and
- The resource implication of establishing a National Entity and funding options that should be considered.

8. Review of surveyor training

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

The Commission is seeking stakeholder input on:

- The priority of carrying out such a review;
- The scope of the review of surveyor training and assessment;
- The timeframe for the review; and
- The resource implication of this review.

9. Associated Reforms

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.

The Commission is seeking stakeholder input on:

- The priority of carrying out each of the proposals;
- The scope of each of the proposals;
- The timeframe for the implementation of each of the proposals; and
- The resource implication of the proposals.

ATTACHMENT 1: Discussion Paper Proposals

The Commission's Discussion Paper – *National Safety and Quality Accreditation Standards* put forward twelve proposals for reform of the safety and quality accreditation system for health. Stakeholder comment strongly influenced the subsequent recommendations to Health Ministers on how each of the proposals could be progressed. An overview of these responses follows:

1. Registration of accreditation bodies

Stakeholders were concerned that the establishment of a register may be bureaucratic and costly, without adding value to the process. They viewed the major benefit of an accrediting bodies' register was its potential for collecting national data. The proposed establishment of a National Entity, as described in the alternative model, and a process to recognise or endorse accrediting bodies to undertake safety assurance assessments, may eliminate the need to progress this proposal.

2. Standardisation of language accreditation

Overall, there was agreement that there would be benefit from developing common definitions or terminology relating to high-level accreditation terms. There is no specific recommendation for this work to progress, but it could evolve because of the establishment of a national coordination body or be incorporated into work of the National Entity described in the alternative model.

3. Training of surveyors

There was overall support for a review of training and other support of surveyors from stakeholders. Because of the continuing importance of surveyors in the accreditation process this issue will be considered in final recommendations to Health Ministers.

4. Use of accreditation data

The Discussion Paper proposed the use of nationally aggregated data to identify safety and quality trends. The proposal in the alternative model to introduce minimum safety assurance standards that apply across all (like) settings of care will provide data on priority safety issues. It is anticipated that the quality improvement framework, the establishment of which is recommended as a role for the National Entity, will include mechanisms for public reporting.

5. Accreditation of all settings of care

While there were diverse opinions on the benefits of accrediting all settings of health care, there was general acknowledgement that some areas of health care should be subject to more external checks than currently exist. Minimum safety standards assessment of all health services provided by registered health professionals, as proposed in the alternative model, could address these concerns and result in better assurance of high risk services for consumers and funders.

6. Unannounced surveys

Stakeholders clearly indicated that this proposal should involve a pilot or trial, rigorous evaluation, and the production of communication and training packages on the intent and process of unannounced surveys before being introduced more widely.

There is potential for this methodology to be used in testing compliance against regulatory minimum safety assurance standards. The alternative model does not address this issue directly, but it will be considered in final recommendations to Health Ministers. It is proposed that the Commission commence work on piloting this methodology in the short term to inform final recommendations.

7. Tracer methodology/ Consumer Journey

Stakeholders were receptive to this concept of greater involvement of consumers in accreditation and some stakeholders recognised the consumer pathway may partly achieve this objective.

There is potential for the consumer pathway to be used for assessing quality improvement of health services. There will be a need to pilot the methodology and then to train health service staff to build, understand and implement this methodology. The alternative model does not address this issue directly, but it will be considered in final recommendations to Health Ministers. It is proposed that the Commission will commence work on piloting this methodology in the short term and to inform final recommendations.

8. Registration of sets of health care standards

The lack of clarity about the intent of the register, the coverage of the proposal and where the register would sit on the regulatory scale made it difficult for stakeholders to provide a meaningful response to this proposal.

The alternative model proposes that a list of safety and quality standards be established by the National Entity. In addition, a process for endorsing standards that are patient-focused and have the capacity to assess patient pathways of care or disease management is proposed in the alternative model.

9. Harmonisation of standards

There was stakeholder support for harmonising the structure of standards. The alternative model does not propose that a specific body of work be undertaken to achieve harmonisation. However, it suggests an evolutionary convergence of standards by establishing a model standard format and structure. All new and reviewed standards will be measured against the model to ensure consistency. Best practice guidelines for standards development will be considered including a requirement that all new standards proposals must demonstrate that they are not replicating currently endorsed standards.

10. Mapping of standards

Some stakeholders considered that mapping was valuable to understand standards coverage, other suggested a best practice framework be developed that standards setting organisations could implement as they reviewed their standards. The alternative model does not address this issue directly, however it will be considered in the development of final recommendations for Health Ministers.

11. Core safety and quality areas

Stakeholder views on this proposal covered the full spectrum from strong reservation to full support. The alternative model recommends the development of minimum safety standards which are developed by the National Entity with the development criteria endorsed by Health Ministers.

12. Mutual Recognition

Stakeholders recognised mutual recognition as having the greatest potential to address their concerns about the duplication, burden and proliferation of accreditation processes. The alternative model progresses this proposal through the establishment of a National Entity that has responsibility for the development of minimum safety standards and a quality improvement framework.

This next stage will need to identify and recognise non-clinical and technical compliance and processes for ensuring there is no duplication of these processes in other assessment processes.

Work in relation to other safety and quality compliance requirements that are not part of the accreditation process (such as state and territory licensing requirements, quality assessments required by funding bodies such as the Commonwealth agencies and private health insurers) will be undertaken simultaneously, but separately, by the Commission.

ATTACHMENT 2: Registration status of health professional by state and territory

	NSW	Vic	Qld	WA	SA	Tas	NT	ACT
Aboriginal health workers							X	
Audiology								
Chinese medicine		X						
Chiropractors	X	X	X	X	X	X	X	X
Clinical psychology	X	X	X	X	X	X	X	X
Community pharmacy	X	X	X	X	X	X	X	X
Dental prosthetics		X	X	X	X	X		X
Dental technicians	X		X					X
Dental therapists/hygienist		X	X			X		
Dentists	X	X	X	X	X	X	X	X
Diagnostic radiography/sonography	X	X	X	X	X	X	X	X
Dietetics								
Hospital pharmacy	X	X	X	X	X	X	X	X
Medical practitioners	X	X	X	X	X	X	X	X
Nuclear medicine technology	X	X	X	X	X	X	X	X
Nursing	X	X	X	X	X	X	X	X
Occupational therapists			X	X	X		X	
Optical dispensers	X							
Optometrists	X	X	X	X	X	X	X	X
Orthoptics								
Orthotics and prosthetics								
Osteopaths	X	X	X	X	X	X	X	X
Physiotherapy	X	X	X	X	X	X	X	X
Podiatry	X	X	X	X	X	X		X
Radiation therapy	X	X	X	X	X	X	X	X
Social work								
Speech pathology			X					

Source: adapted from Australian Health Workforce Advisory Committee (2004), The Australian Allied Health Workforce – An Overview of Planning Issues, AHWAC, Report 2006.1, Sydney. pg 33.

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