

DRAFT
**AN ALTERNATIVE MODEL FOR
SAFETY AND QUALITY
ACCREDITATION**

NOVEMBER 2007

TABLE OF CONTENTS

INTRODUCTION	1
1. AN ALTERNATIVE MODEL FOR ACCREDITATION	2
1.1 Developing the Alternative Model	2
1.2 Australian Health Standards	6
1.3 Quality Improvement Framework	13
1.4 An expanded scope for accreditation	15
1.5 National Data Collection and Reporting	17
1.6 Initiatives to support mutual recognition.....	20
1.7 Review of Surveyor Participation	21
1.8 Piloting Innovative Assessment Mechanisms	22
1.9 Research	23
1.10 National Entity.....	24
1.11 Formal obligations to comply and consequences of non-compliance.....	26
APPENDIX 1	31
APPENDIX 2	32
APPENDIX 3	33

Introduction

The *Alternative Model for Safety and Quality Accreditation* (the *Alternative Model*) brings together views and information collected over 2007 in two phases of consultation with stakeholders. The *Alternative Model* is designed to be applied across all sectors of the health care system and be implemented incrementally, commencing with high risk services.

This paper is intended to provide stakeholders with an overview of how the *Alternative Model* would operate, prior to seeking final comment as part of a National Workshop on 30 November 2007. Final recommendation on the *Alternative Model* will be forwarded to Health Ministers in March 2008.

The *Alternative Model* has the following key elements:

- *Developing an alternate model for accreditation* that includes principles to guide implementation of the reforms (section 1.1).
- *Australian Health Standards* that would apply to health services appropriate to the service and settings, developed in collaboration with clinicians, consumers and other stakeholders (section 1.2).
- *A Quality Improvement Framework* to encourage and support improvements in care for consumers. It incorporates an integrated approach with safety, non-clinical and technical compliance being considered within a quality improvement framework (section 1.3).
- *An expanded scope for accreditation*, with initial priorities based on risk (section 1.4).
- *National data collection and reporting* to measure performance outcomes and improvements in priority safety and quality areas, to allow credible service comparison and facilitate tracking of the effectiveness of the Australian Health Standards (section 1.5).
- *Initiatives to support mutual recognition* and minimise the burden of accreditation on health services (section 1.6).
- *A review of surveyor participation*, to enable development of strategies ensuring the appropriate expertise to undertake accreditation (section 1.7).
- *Piloting of innovative assessment mechanisms and research* such as patient journey methodologies and unannounced surveys, to improve efficient use of accreditation and service resources (section 1.8 and 1.9).
- *National coordination* of the accreditation system aimed the rights of consumers are met and providing a model of collaborative governance that gives a clear role for consumers, clinicians, service providers and other stakeholders. (section 1.10)
- *Beginning of a move to implement formal obligations to comply and consequences of non-compliance* by Health Services, including through regulatory mechanisms (section 1.11).

1. An alternative model for accreditation

1.1 Developing the Alternative Model

The Commission understands the purpose of accreditation is to promote and support safe patient care and continuous quality improvement of services. Accreditation can achieve this through two interrelated processes:

- Developing of standards that test and measure the effectiveness, appropriateness, efficiency and quality of care delivered.
- Assessive health service against the standards.

In developing the *Alternative Model* requested by Health Ministers, the Commission has focused on the reasons for reforming the current accreditation system set out in *Draft Report on The Review of National Safety and Quality in Accreditation: November 2007*.

The Commission considers that any accreditation system should:

- Reflect the purpose of accreditation - promoting and supporting safe patient care and continuous quality improvement of health services.
- Comply with clear principles which underpin the accreditation system.

In exploring options for the *Alternative Model*, the Commission has considered whether the model should focus separately on safety and quality, or address safety and quality in an integrated way. The Commission has concluded that the *Alternative Model* should adopt an *integrated approach*, with safety, non-clinical and technical compliance being considered within a quality improvement framework.

Guiding Principles for the Alternative Model

Some stakeholders suggested that the identification of principles for the *Alternative Model* would be helpful to both finalise the *Alternative Model* of accreditation and to guide the implementation of reforms. The former Australian Council on Safety and Quality in Health Care developed a set of principles for accreditation reform that were endorsed by Health Ministers in July 2003. These are listed in Appendix 1. The intent of these has been incorporated into the following principles and is reflected in the *Alternative Model* of accreditation proposed by the Commission.

The Commission proposes that systems and processes to accredit Australian health services comply with the following guiding principles:

1. Consumers will receive health care delivered at established standards of safety and quality that support good health care outcomes.
2. Accreditation is an important and useful safety and quality mechanism. Compliance with established standards of safety and assessment of quality improvements has the potential to improve health care outcomes.
3. Adoption of Australian Health Standards will contribute to standardised care.
4. The range of Australian Health Standards applying to a health service will vary according to the setting of the service, the nature of the health care provider and the risks involved.

5. Australian Health Standards will be evidence based with their outcomes measurable and formulated in consultation with stakeholders, including clinicians, consumers and managers.
6. Measurement of compliance with Australian Health Standards in an accreditation process will include independent external review.
7. Continuous quality improvement is an objective of all health services, and systems and mechanisms to measure improvement will be flexible and take account of service type and settings.
8. The financial and administrative costs of participation in accreditation processes will be minimised and be consistent with ensuring safety and quality.
9. Governance structures will involve collaboration between stakeholders, including clinicians, consumers, health service providers and governments.
10. Arrangements to establish or require accreditation will be simple, avoid duplication and support mutual recognition.

Benefits of the *Alternative Model*

Current Strengths

The *Alternative Model* builds on the strengths of the current accreditation system which are that:

- A high proportion of public and 100% of private hospitals undertake accreditation.
- Involvement of clinicians as surveyors encourages information sharing, an understanding of the application of service standards and exposure to health service in other jurisdictions.
- Accreditation promotes change in health services and supports organisational learning and decision making processes.

Additional benefits

The *Alternative Model* of accreditation offers a number of additional benefits including:

- addressing weaknesses such as a lack of co-ordination, fragmentation (section 1.9) and duplication (section 1.6) in the current accreditation system
- more active roles and collaborative for clinicians, consumers and other stakeholders, including through their involvement in governance arrangements (section 1.9)
- building in evaluation to ensure that changes to the system deliver improvements and are effective through the national analysis of data
- targeting safety and quality risks by tailoring quality improvement activities to areas of greatest organisational need (section 1.3)
- targeting safety and quality strengths by identify outstanding quality practice, the lessons of which could be shared with other health services (section 1.3)
- providing clarity about areas where safety and quality improvements can be progressively achieved (section 1.3)

- identifying priority areas in which standards of expected performance for improving safety and quality should be applied across health services (section 1.2)
- measuring improvements in priority safety and quality areas (section 1.5)
- consistently applying Australian Health Standards across health services (sections 1.5 and 1.9)
- providing an information base for safety and quality improvement across the health system (section 1.5)
- extending accreditation to cover high risk areas and encourage all services to comply with Australian Health Standards (section 1.2)

Whilst the Commission has reviewed international approaches to health care accreditation, there is no international model that addresses all our goals and principles or provides the range of benefits identified above. However, international learnings and best practice have informed the *Alternative Model* where appropriate.

Overview of the *Alternative Model*

The Commission believes the proposed alternative accreditation model, developed with stakeholders could deliver greater benefits to consumers and the health practices.

The *Alternative Model* has the following key elements:

- *Developing an alternate model for accreditation* that includes principles to guide implementation of the reforms (section 1.1).
- *Australian Health Standards* that would apply to health services appropriate to the service and settings, developed in collaboration with clinicians, consumers and other stakeholders (section 1.2).
- *A Quality Improvement Framework* to encourage and support improvements in care for consumers. It incorporates an integrated approach with safety, non-clinical and technical compliance being considered within a quality improvement framework (section 1.3).
- *An expanded scope for accreditation*, with initial priorities based on risk (section 1.4).
- *National data collection and reporting* to measure performance outcomes and improvements in priority safety and quality areas, to allow credible service comparison and facilitate tracking of the effectiveness of the Australian Health Standards (section 1.5).
- Initiatives to support *mutual recognition* and minimise the burden of accreditation on health services (section 1.6).
- *A review of surveyor issues*, to enable development of strategies ensuring the appropriate expertise to undertake accreditation (section 1.7).
- *Piloting of innovative assessment mechanisms and research* such as patient journey methodologies and unannounced surveys, to improve efficient use of accreditation and service resources (section 1.8 and 1.9).

- *National coordination* of the accreditation system ensuring the rights of consumers are met and providing a model of collaborative governance that gives a clear role for consumers, clinicians, service providers and other stakeholders. (section 1.10)
- Beginning a move to implement *formal obligations to comply and consequences of non-compliance* by Health Services, including through regulatory mechanisms (section 1.11).

These are discussed in detail below. In some cases, the Commission has identified a number of options for implementing an aspect of the model.

1.2 Australian Health Standards

The *Alternative Model* will establish best practice Australian Health Standards (AHS) in priority areas to support improvements in the safety and quality of health care.

The Commission considers that AHS are the most effective way of describing the expected level of service for consumers across the health system. Accordingly, the Commission believes that all health services should comply with the AHS.

Characteristic of Australian Health Standards

The characteristics of AHS are consistent with the work undertaken on national safety and quality standards by the former Australian Council on Health Care in Australia and the recommendations of the Paterson review. It is recommended that AHS be:

- measurable
- definable
- reproducible
- quantifiable
- focused on patient safety and quality
- developed using transparent processes, which involve relevant expertise including clinicians, consumers and service providers
- credible
- based on the best available evidence
- freely available to all stakeholders
- applicable or adaptable across health service environments
- externally validated.

Scope of standards

Initial work undertaken by the Commission has identified a number of domains where there is evidence that consumers are harmed because of systems failures. The Australian Health Standards would focus on these domains with potential for improved consumer outcomes. . They include:

- hygiene and health service acquired infection
- patient identification
- open disclosure
- medication management
- clinical handover
- falls.

These areas are also a subset of the Priority Focus Areas that the Joint Commission on Accreditation of Healthcare Organisations (USA 2006) has identified as significantly impacting on safety and or the quality of care provided.

The list of priority areas for development of AHS will be developed in collaboration with stakeholders. Work underway in the Commission and jurisdictions and by expert groups will inform and support the development of the AHS. Expert clinical and consumer collaboration will be fundamental to the development of Australian Health Standards, which will be developed through the process outlined below.

Preventing major systems failures

The AHS will be developed in the areas where evidence shows there is the greatest potential to prevent harm to consumers. However, it is important that the *Alternative Model* of accreditation consider how AHS can preclude accredited services from significant systemic failures in patient care or serious adverse events.

Initially AHS will not cover all aspects of safe care. Over time, there will be benefit from developing or endorsing standards specific to areas, for example, maternity or primary care practice.

The primary focus of AHS will be clinical. The culture of an organisation is an established determinant of safety and quality of care. Major reviews have identified a range of cultural factors, such as lack of effective communication and collaborative decision-making, hierarchical structures, and limited team training as factors leading to system breakdown. It is considered important to address these cultural factors through AHS. Alternatively, a national coordinating body (the *National Entity*, see section 1.9) could work with stakeholders to identify standards that identify best practice and/or standards to determine the risk factors and early warning signs of major failures to prevent their occurrence.

Development of standards

Priority areas for Australian Health Standards will be identified and initial standards developed over a two year period. The emphasis will be on high risk areas where there is potential to deliver improved health outcomes. It will be important for the *National Entity* to work with stakeholders to identify which improvements in health outcomes are being sought, how these will be measured, and which AHS will improve outcomes. The data collected will be used to measure the improved health outcomes.

The *National Entity* will be responsible for developing and verifying standards in collaboration with clinicians, technical and other experts including consumers and the Commission. The development process will be transparent with full public exposure of draft standards. Public comment on draft standards will be sought, for example by publishing the draft on the *National Entity*'s website for feedback.

Decisions on standards

Governments and Health Ministers are accountable to the community for the safety of the health system. Giving the Australian Health Ministers Conference (AHMC) a role in the standards setting process recognises this accountability.

AHMC's role will be to:

- Endorse Australian Health Standards priority areas identified by the *National Entity* after discussion with clinicians, consumers, service providers, and the Commission.
- Endorse the Australian Health Standards developed through a transparent and inclusive processes by the *National Entity*.
- Receive advice from the *National Entity* on monitoring and reporting against the standards.

The process provides a clear separation between standards development and assessment.

Recognition of Australian Health Standards (AHS)

AHS will be freely available to the health system. There is a recognised need for standards that are applicable to specific services or settings of care and this would be a key component of AHS development.

The Commission recognises the significant investment of professional groups in the development of existing standards. The Commission proposes a process to recognise existing standards that are considered equivalent in scope, content and level of performance to AHS. The process would involve the development of agreed criteria against which standards, such as those produced by standard setting bodies, professional groups or for disease specific services, could be endorsed or recognised. The final criteria would be developed by the *National Entity* in collaboration with stakeholders, but indicative criteria might require existing standards to be:

- recognised by an international body, such as JASANZ, ISQua or an equivalent body
- equivalent or requiring a higher compliance than the *National Entity*'s best practice standard
- current and up to date, and
- applicable nationally to similar services.

The benefits of the proposed endorsement process are that it:

- Retains the significant resource investment in standards development made by professionals and service providers.
- Enables the lead time and implementation of the Australian Health Standards to be streamlined by building on effective aspects of the current accreditation system.
- Leads to more consistency between standards and convergence of standards over time.

Separation standards setting and assessment

The need for a separation of standards setting and assessment against those standards as a requirement of good governance is widely acknowledged. The establishment of a *National Entity* that has responsibility for the development of Australian Health Standards addresses the issue of separation.

Reviewing standards

AHS will need to be updated or withdrawn when no longer appropriate or current. Additional standards will need to be developed as priority issues are identified. Governance structures and changes consideration principles will be required to ensure an appropriate balance between the safety and quality improvements that new AHS can deliver and the compliance burden for health services.

Application of Australian Health Standards

Health services will only be required to comply with Australian Health Standards relevant to them. For example, the falls standard may not apply to services that are primarily for ambulatory consumers. Similarly, the infection control standards for patient and health care worker protection are likely to apply in all settings of care, while environmental control standards, such as cleaning, sterilizing ventilation and air conditioning are likely to apply variously.

Bodies Assessing Australian Health Standards

It is proposed that a national body will have responsibility for authorizing accrediting bodies to assess against the Australian Health Standards. There will be explicit criteria for obtaining authorization developed in collaboration with stakeholders including accrediting bodies. It is envisaged that as a minimum assessment bodies will be required to:

- Hold JASANZ, ISQua or equivalent recognition for assessment processes and processes associated with managing surveyors.
- Demonstrate independence from the health services it assesses and has no conflict of interest in relation to services provided.
- Agree to provide data collected on the Australian Health Standards to the *National Entity*.
- Agree to provide advice to the *National Entity* on unresolved non-compliance against an Australian Health Standard as defined in the relevant AHS.

Information about the authorised assessment bodies could be made available publicly on a website hosted by the *National Entity* or by providing links to relevant sites and organisations. This information could be used by health services to determine which organizations are eligible to provide assessment services and the service types they cover. This proposal is designed to:

- Provide clarity for both consumers and service providers about the accreditation services available and the health services that they accredit.
- Ensure that all accrediting bodies assessing against the Australian Health Standards meet basic quality and independence requirements.
- Ensure that data on agreed safety and quality outcomes relating to the Australian Health Standards are provided to the *National Entity* to enable trends and improvement to be identified.
- Ensure that unresolved non-compliance, as defined in a Australian Health Standard, is reported to the *National Entity* to enable follow up action.

The proposal could broaden the range of accrediting bodies. Initially, services not currently subject to accreditation will be required to comply only with the AHS. Assessment of these standards could be undertaken by an existing accreditation assessment body, or alternatively by professional associations or specialist medical colleges which may wish to seek authorization to assess against the Australian Health Standards and provide accreditation options to their members. JASANZ, ISQua or equivalent accreditation process are not burdensome or expensive, and are outlined at Appendices 2 and 3.

Innovative assessment mechanisms

There is a range of assessment mechanisms that can be used in an accreditation process. The Commission considers that there are two essential components to any accreditation process. The first is that all health services are subject to periodic external assessment, as this is considered to be one of the key drivers of organisational change. The second is that peer review continue to be a characteristic of assessment. The Commission considers that peer review is essential to assessing the effectiveness of a clinical service and providing cross-organisational learning and information sharing.

The review process has shown the vast majority of accreditation survey teams are made up of health practitioners, who survey health services part time or on an ad hoc, infrequent basis. Employers have traditionally supported accreditation through the release of staff from their clinical duties to act as surveyors at other facilities. The cost to employers of releasing staff has been off-set at least partially by the benefits of shared learning and exposure to different services. However, a growth in demand for health services and workforce shortages has made it increasingly difficult for employers to release staff to participate in site surveys and for clinicians to leave their patients.

The proposed expansion of accredited services provides an opportunity to access a new pool of surveyors, but is likely to increase pressure on the existing surveyor workforce.

Assessment processes

The Commission considers that there are sufficient benefits of external assessment against safety and quality standards to warrant including external assessment in the accreditation cycle. Organisations will remain able to undertake self assessment against standards, and self identify areas for improvement. However, external assessment also provides a timeline for measuring changes and an opportunity for feedback on progress.

Assessment processes will need to be matched against the complexity and risk of a service. For example, tertiary acute care facilities warrant a more comprehensive assessment process due to the complexity and high-risk nature of their services, while low risk, small practices, such as a consulting service, could be assessed using a less comprehensive assessment process. Three assessment options are described below:

Option 1	Option 2	Option 3
<p>Traditional comprehensive accreditation process, over a 3 or 4 year cycle including:</p> <ul style="list-style-type: none"> • Self assessment against standards • Implementation of a quality improvement action plan • Assessment by external reviewers • Action on recommendations within specified timeframes • Follow up and focus visits as required. These could be planned visits or short notice spot visits, and • Submission of performance indicator data. 	<p>Modified accreditation process that may occur over a longer period, say 4-5 years, that includes:</p> <ul style="list-style-type: none"> • Self assessment against standards • Implementation of a quality improvement action plan • Desk top audit of self assessment reports • Assessment by external assessor of an agreed percentage of responses, based on random selection or identification of issues in self assessment returns. These could be planned or short notice, spot visits • Submission of performance indicator data, and • Planned external assessment every 4-5 years. 	<p>Limited accreditation of a service that may occur annually in a 4-5 year cycle, including:</p> <ul style="list-style-type: none"> • Self assessment against standards • Random assessment by external assessor of an agreed percentage of responses • Planned external assessment every 4-5 years, and • Submission of performance indicator data. <p>An inspection may be triggered if reports demonstrate a service is not meeting the required performance level against standards</p>

These options could be applied differently to classes of health service depending on risk and complexity. Whichever option is adopted, it will be essential that systems are established to feed back data from assessments to health services and clinicians as a mechanism for changing practice.

Appeals

The model contains two types of review right.

The first provides a new mechanism to resolve disputes between health services and accrediting bodies that does not currently exist. Unresolved disputes could be forwarded to the *National Entity* for resolution. Initially, the *National Entity* will undertake a robust process of assessment and review to attempt to resolve the matter. In the longer term, the process of establishing the *Alternative Model* could formalise a review process. The *Alternative Model* could also include dispute resolution procedures and outcomes as one of the issues the *National Entity* could take into account when authorizing an accrediting body to assess against the AHS.

The second provides a right of overview of accrediting bodies not authorised or re-authorised, to accredit health services against AHS. In the short term, this could be achieved by arbitration/mediation by a mutually agreed party. In the longer term, the process of establishing the *National Entity* could explore making its decisions subject to review by the relevant administrative appeals tribunal.

Potential for the standards to contribute to continuity of care

Continuity of care across sectors is important for the health outcomes of consumers who access a range of services. The establishment of Australian Health Standards could improve the continuity of care. The identification of domains and the development of matching suites of standards will enable Australian Health Standards to be extended to related sectors such as community care, home care and health services provided as part of aged care services, as appropriate. Consumers, state health departments and some of the providers in these sectors have suggested this would reduce the current fragmentation of the system.

1.3 Quality Improvement Framework

The *Alternative Model* for accreditation recognises the importance of health services engagement in quality improvement activities and the need to support and enhance these activities. The proposed Quality Improvement Framework would:

- Provide guiding principles for continuous improvement in the *Alternative Model*.
- Support and enhance health service engagement in quality improvement activities.
- Identify opportunities for improvement and shared learning.
- Provide the opportunity to showcase exemplary practice.

Scope of the Quality Improvement Framework

The Quality Improvement Framework (QIF) will establish an overarching structure for quality improvement activities. A QIF could be a short document providing overarching principles for best practice quality improvement. Common areas dealt with in QIFs are leadership, communication, clinical practice improvement, consumer involvement, systems improvement, risk management, education, governance and information management. A national QIF will facilitate links to safety, better practice and a clearer benchmark for quality improvement. The Quality Improvement Framework could provide direction for services making decisions about their investment in quality improvement and support those organisations that have embarked on the safety and quality journey more recently.

The Quality Improvement Framework will focus on quality improvement activities and, possibly on areas that are less likely to be the subject of clinical Australian Health Standards such as key corporate, risk and governance areas.

As suggested by the Paterson Review, the Quality Improvement Framework could clarify the respective roles and responsibilities of jurisdictions, state-based safety and quality bodies, professional and sector specific bodies (e.g. professional colleges, health funds etc). It could facilitate a coordinated approach which minimises duplication and could demonstrate the *National Entity*'s commitment to a consultative and inclusive approach to safety and quality improvement.

Streamlining the accreditation process

One way that the *Alternative Model* could streamline current accreditation investment is by establishing the key requirements for safety and quality accreditation through AHS and the Quality Improvement Framework. If the QIF specified the broad areas that should be considered in any basic accreditation process appropriate to particular service groups, this could provide an opportunity for services to negotiate with accrediting bodies to offer accreditation products that are more tailored to their needs. If supported, this option has the potential to streamline and better focus accreditation processes. It will result in a set of key requirements with the capacity for add ons as negotiated with an accreditation provider i.e. a modular approach. The content of the QIF will be developed collaboratively with stakeholders as described below.

Development of the Quality Improvement Framework

The *National Entity* will be responsible for developing the Quality Improvement Framework in collaboration with clinicians, technical and other experts including consumers and the Commission. The development process will be transparent and include a public exposure draft.

The Quality Improvement Framework could be implemented in a number of ways, including:

- Developing principles that apply to all Quality Improvement Frameworks.
- Identifying best practice examples of Quality Improvement Frameworks that could be adopted or adapted by health services.
- Developing a national model Quality Improvement Framework that services could adopt or adapt.

These options could be developed sequentially. It will be necessary to develop key principles and elements of a Quality Improvement Framework to enable best practice examples to be identified or build a model framework. Depending on stakeholder support, there could be further work to develop an actual resource to be adopted or adapted by services. This could be a list of best practice examples or a model framework that met the principles and key elements.

The Commission considers that all health services should implement an appropriate quality improvement framework. Options for achieving this outcome include:

- Implementation of a Quality Improvement Framework as an Australian Health Standard, with compliance assessed during the accreditation process and reported to the *National Entity*.
- Tools and guidelines to assist implementation by health service developed by the *National Entity*. Reporting of achievements in quality improvement will be encouraged and recognised.

1.4 An expanded scope for accreditation

The Commission considers that all health services should be required to implement measures to ensure they comply with Australian Health Standards consistent with reasonable consumer expectations of safe and good quality care. However system wide accreditation of all health services would be a significant expansion of current practice and not a feasible option in the medium term without the introduction of regulatory mechanisms in all states and territories by Health Ministers.

While the Commission sees benefits from accrediting all health services, it recommends that initially only health services with a high risk of patient harm are accredited. The Commission therefore intends to recommend to Health Ministers a risk-based and staged approach to the implementation of accreditation across health settings focusing on priority areas with robust evaluation before broader implementation.

The *National Entity* will finalise the criteria for classifying high risk services in collaboration with stakeholders including consumers and clinicians and identify health services that fit these criteria and are not currently accredited. Indicative criteria may include services that:

- Undertake ‘invasive’ procedures into a sterile body cavity or dissect skin (excludes penetration by needles).
- Perform musculoskeletal manipulation.
- Apply biomedical equipment to a consumer where it has the potential to burn or irradiate.
- Medicate patients to anaesthetise or sedate.

The risk rating criteria will be applied consistently to health services whether they are provided by registered or non-registered health professionals.

Implementation of accreditation processes

If Health Ministers endorse the Commission’s recommendation for mandatory accreditation of high risk services, the implementation mechanism for services will may differ, because of the diversity of service delivery and other factors.

Many high risk services are already required to be accredited, under funding agreements, contracts with private health insurance funds or as a result of policy decisions by governing bodies. Other services could be required to be accredited using the same mechanism. For example, health insurance companies could require service providers to demonstrate they are accredited against Australian Health Standards as part of their enrolment. However, some high risk service providers are not captured by these mechanisms e.g. cosmetic surgeons providing invasive procedures in their rooms that are funded directly by consumers. Therefore regulatory mechanisms to ensure consistent mandatory accreditation of high risk service providers may need to be pursued.

Before accreditation is expanded beyond high risk services an evaluation is proposed of the first phase of implementation, including consideration of the cost benefits of mandating accreditation more directly and an analysis of the applicability and

appropriateness of Australian Health Standards across all health services. The evaluation could also consider the basis on which the accreditation system be expanded should that be recommended.

The Commission does not have direct responsibility for the mechanisms that could achieve this outcome. Health Ministers may wish to consider whether a mechanism to mandate accreditation of high risk services be identified in the remit of the *National Entity*, subject to satisfying a cost-benefit analysis and other necessary impact assessment. In the meantime, the Commission will urge organisations with current responsibility for mechanisms to regulate and similar extend accreditation to all high risk services.

Mechanisms to address enforceability are addressed in section 1.10.

1.5 National Data Collection and Reporting

Data collection

Data collection is essential to the success of the reforms. It will:

- Assess the safety and quality of services provided to consumers across the Australian Health Standards domains.
- Provide information about the rate and coverage of implementation.
- Evaluate the success of the reforms.

The *Alternative Model* proposes that data on Australian Health Standards are collected. These could build on the work being undertaken by the Commission, including:

- Identification of existing data sets and the potential for that data to generate safety and quality indicator information.
- Gaps in data collection and how they may be addressed.
- Identification of up to 50 national safety and quality indicators that will be reported publicly using existing data sets.
- Development of data sets and data standards for the collection of new data items.

This work will provide information to support national safety and quality initiatives, such as clinical handover and infection control, and allow for better targeting of accreditation assessments.

However, a tension exists between constraining the number of variables collected to minimise the burden and maximise accuracy, and obtaining sufficient data to provide meaningful information on the safety and quality of a service. Therefore and wherever possible, data from routine data collections will be used.

The *Alternative Model* proposes that health services will submit dis-aggregated data to their authorised accrediting body on a regular basis. This data will be forwarded to the *National Entity*. Collection may be annually or more frequently, depending on the type of data, the standard being measured and stakeholder recommendations. For example, it is anticipated initial reporting in relation to the National Framework for Quality Improvement will be minimal and limited to confirming that:

- Health services are applying and being assessed against a quality improvement framework.
- The framework complies with ‘best practice’ requirements as specified by the *National Entity*.

In addition to data collected directly from health service accreditation processes, the *National Entity* may use other data sources to verify data submitted to the inspection body and to identify health services requiring more frequent inspection. Such data sources are more likely to be available for large institutional services, e.g. separations data and casemix inpatient information collections.

The long term intent is to report on exemplar practice and share learnings that could provide broader system changes and improvements in safety and quality.

Data characteristics

The specific data items to be collected will be determined in collaboration with stakeholders as part of the development of the Australian Health Standards. Standards piloting will establish the validity, reliability, potential coverage and ease of collection for any new data item. The quality of the data collected, the relevance of that data, the data design, data linkage and timely analyses will need to be defined by the *National Entity* in consultation with stakeholders and data experts.

The data variables should be well-defined and relatively easy to measure, and should not be changed unnecessarily from year to year. This will allow for the collection of trend data and comparison between like services. It will be important that data is received in a timely way with minimal lag time between collection and submission.

Collaboration in developing the standards and selecting data elements will ensure that the information generated is clinically meaningful. This will allow health care providers to change or support their practice and consumers, funders and health services to assess the safety and quality of a service.

The Commission is currently working on national safety and quality indicators. This work aims to identify relevant safety and quality indicators in existing data collections that can be collected nationally. This work will inform data requirements for the AHS and *Alternative Model*.

Data usage

Self assessment and reporting against performance indicators could be done in a web-based format to limit the effort associated with data submission. Information generated from the data will be used to:

- Focus accreditation on issues that need detailed review or identifying health services that should be subject to random audit.
- Provide reports back to health services on performance.
- Inform the development and review of Australian Health Standards.
- Inform national policy and investment in the safety and quality of health care.

It is not intended that the data be used to establish league tables. League tables have been introduced in both the United Kingdom and United States of America where there has been a mixed reaction to their use. Supporters suggest league tables stimulate competition, encourage the adoption of 'best practice' and increase the emphasis in health services on quality rather than unit cost. Critics¹² however suggest that league tables are not statistically sound or robust, noting:

- It is difficult to disentangle genuine performance variance from statistical random fluctuations.

¹ Jacobs R, Goddard M and Smith PC. Composite performance measures in the public sector. Centre for Health Economics. University of York, United Kingdom. January 2007

² Adab P, Rouse AM, Mohammed MA, Marshall A. Performance league tables: the NSH deserves better. *BMJ*. 2002. Vol 324. pg 95-98.

- The ranking awarded using aggregated data is sensitive to the methodology used.
- The weighting of data and the ‘decision rules’ can have a significant impact and need to be managed with caution.
- To interpret rankings requires indicators of uncertainty to be made public.
- Alternate tools, such as control charts that monitor and control for variation can display performance ranking, may be more appropriate.

Datasets for multiple purposes

A significant burden for private health services is the duplication that comes from multiple safety and quality data requirements imposed by health insurance funds, State licensing requirements and State-based Safety and Quality entities, in addition to accreditation requirements. Identifying a data set that is supported by all stakeholders including service providers and the health insurance industry is likely to lead to greater consistency in the data collected and therefore an overall reduction in the compliance burden. The proviso will be that data are both timely and accurate.

Public Reporting

The *Alternative Model* will involve the *National Entity* reporting publicly on the accreditation status of individual services (i.e. accredited or not, similar to current Australian Council on Healthcare Standards practice) and aggregated national data on the safety and quality of health services. In addition, the *National Entity* will produce a national report on performance against the Australian Health Standards. The frequency and characteristics of reporting will require further discussion with stakeholders. The *Alternative Model* will not produce a league table of services but will explore ways to enable similar service types to benchmark against each other.

1.6 Initiatives to support mutual recognition

Mutual recognition in this context relates to a process to eliminate duplication of accreditation processes, where services are required to complete multiple separate assessments with different assessment bodies. It does not relate to reducing duplication of other processes, such as reporting of health indicators or service data in different formats to different funding bodies.

The majority of stakeholders supported the proposal to introduce mutual recognition because of its potential to reduce duplication, cut red tape and decrease the compliance effort and proliferation of accreditation processes. Although not a primary objective of this reform, a more efficient system could increase capacity and the availability of resources to address service demand and safety and quality issues.

The *Alternate Model* will need to ensure mutual recognition does not leave gaps in care continuity. It is at key handover points that there is a greater risk of harm to patients because of breaks in information or systems flows. The *National Entity* will need to work with stakeholders, in particular assessing bodies to ensure this matter is addressed.

There are three specific areas where mutual recognition could be applied. The first relates to compliance with state, territory, Commonwealth or local government non-clinical regulated areas such as food safety, storage of clinical hazards and fire safety. In each of these areas, where an external assessment is undertaken, it should not be necessary for an assessing body to repeat or duplicate this assessment process.

Secondly, mutual recognition should be sought where accreditation processes establish and maintain quality and safety, but have a secondary role in ensuring accountability of services administered and funded under Medicare. These programs would include accreditation of pathology, diagnostic radiology and nuclear medicine.

The third category is mutual recognition between assessing bodies authorised by the *National Entity*. The mechanism to formalise agreements between these bodies could be explored by the *National Entity*. This may involve the development of principles on the way organisations could work together to achieve mutual recognition or the *National Entity* could be more involved and facilitate mutual recognition agreements between organisations.

1.7 Review of Surveyor Participation

On site assessment by surveyors will remain an important feature of the accreditation process. However, the issues of surveyor consistency, objectivity and workforce need consideration if the system is to capitalise on the contribution made by surveyors. Peer review has played a central role in the assessment of services and sharing of information that occurs at accreditation and will continue to play a significant role under the proposed reforms. In addition, it will be important to expand opportunities for consumers to participate as surveyors.

The Commission recommends a review of existing arrangements by accreditation bodies for surveyor:

- selection
- orientation
- training
- assessment
- maintenance of competency
- supervision
- performance management
- acknowledgment and support.

The review will seek to:

- Identify and describe surveyor characteristics and processes.
- Examine current literature and practices in relation to surveyor training.
- Identify elements of an effective 'best practice' model of surveyor participation in accreditation.
- Compare the information from the review with the relevant standards used by ISQua, JASANZ and similar bodies in their accreditation processes.

It is not intended that the *National Entity* will have a long term role in monitoring or assessing surveyor participation in assessment bodies. The review will consider mechanisms for incorporating its findings into existing processes to ensure the uptake of best practice selection, management and support for surveyors. For example, post-review, authorisation of assessment bodies may be dependent on them complying with best practice requirements for surveyor participation.

The review will describe the characteristics of the surveyor workforce, including:

- who makes up the workforce by sector, clinical, non-clinical, service type etc
- average number of surveys undertaken
- paid verse unpaid surveyors
- costs of participation and who is meeting these costs, and
- trends in participation on surveys.

With the reforms proposing a substantial increase in the number of accredited services, this information would be used to determine the sustainability of the surveyor workforce and options for addressing the barriers that are identified.

1.8 Piloting Innovative Assessment Mechanisms

The November 2006 Discussion paper proposed a range of operational reforms. Some of these reforms were supported and others were supported subject to there being additional evidence or testing of the proposal before its wider application.

Mapping

Stakeholders considered this a valuable exercise in understanding the extent and gaps in the current accreditation system.

This reform will be progressed as part of the development of Australian Health Standards and criteria for endorsing professional and service specific standards. The exercise will map standards prospectively to avoid the issue of standards becoming outdated and the mapping exercise obsolete after a very short time. Responsibility for this work would rest with the *National Entity*.

Best Practice Model of Developing Standards

The initial proposal recommended that the language and definitions of accreditation be standardised and that guidelines for the convergence in format and structure of standards be developed. Stakeholders supported this proposal, recommending that a general framework or best practice structure for standards be developed for use by all standard setting bodies.

It is proposed that a best practice model for standards be developed that can be applied to the Australian Health Standards. This could be undertaken in consultation with specialist organisations, such as Standards Australia. It is intended that the Australian Health Standards and the best practice model be freely available.

Piloting Patient Journey Methodologies (Tracer) and Unannounced Surveys

Stakeholders who provided comment on the introduction of tracer methodology generally supported a greater focus on consumers in the accreditation process. However, there was uncertainty about whether patient journey methodologies are the best way to achieve this and it was recommended that the methodologies be piloted before inclusion in the accreditation process.

Unannounced surveys were proposed as part of the onsite survey of accreditation assessments. Stakeholders indicated that if this proposal was pursued, it should focus on specific standards and large and more complex services. Like tracer methodology, it was recommended that, surveys be piloted and evaluated before consideration of implementation into the accreditation process.

If Health Ministers considered these proposals a priority, the Commission could:

- Pilot patient journey methodologies by inviting health services to undertake pilot projects through a tender process.
- Evaluate the use of unannounced surveys in current accreditation systems, their effectiveness and limitations by approaching accrediting bodies to gauge interest in participating.

- Evaluation the pilot projects, internally by project managers and externally with regard to consumer experience of participation.

The outcome of these projects will be assessed to determine the critical success factors and barriers to these methodologies in accreditation. The information could be forwarded to the National Entity for consideration in relation to broader implementation.

1.9 Research

This review process has revealed a paucity of information and lack of coherence in the published literature on accreditation. While research in this area exists, there is a need for greater co-ordination and coherence to maximise resources in areas such as program development, standards development, the effectiveness and critical success factors of accreditation and accreditation costs. The National Entity could have a role in supporting a coordinated approach to accreditation research.

1.10 National Entity

Stakeholders have acknowledged that the current accreditation system is fragmented and uncoordinated. It will be difficult to effectively implement the proposed reforms without a properly resourced national organisation to lead, support and coordinate the change. Reforming the system will also require an investment and commitment from a range of stakeholders. Changing the system has the potential to realise savings, in part from efficiencies, but more importantly from improved safety and quality of care for patients.

As part of the *Alternative Model*, the Commission is recommending that a national body be given the task of leading, supporting and coordinating reform of the accreditation system. The *National Entity* could be established as a new entity or by giving the role to an existing body.

Characteristics of the National Entity

To ensure the effectiveness and credibility of the *National Entity*, the Commission considers the following characteristics to be key to its success. The *National Entity* should:

- Have a national focus.
- Not be aligned with any particular jurisdiction.
- Report to government but operate independently
- Demonstrate skills and experience in the functional areas proposed for the *National Entity*.
- Operate in close collaboration with stakeholders but not be captured by any interest group(s).
- Act impartially and in the public interest.
- Have an understanding of compliance mechanisms.

It is proposed that the functions of the *National Entity* be guided by an advisory committee, constituted by stakeholder nominees representing the broad range of interests in accreditation. The governance arrangements will be developed in collaboration with stakeholders and answer questions such as:

- Whether the body is established as a new entity or within an existing body.
- What, if any, powers the body has to mandate or ensure the inclusion of all services in accreditation.
- What reporting line exists to Health Ministers?

The following are necessary functions that will need to be allocated to appropriate bodies. Some or all could be undertaken by the *National Entity*:

- Standards development
 - Providing recommendations to Health Ministers relating to the domains across which Australian Health Standards are developed
 - Developing best practice Australian Health Standards and criteria against which standards produced by professional groups or disease specific services could be endorsed or recognised.

- Developing and verifying standards in collaboration with technical and other experts.
 - Reviewing and maintaining standards.
 - Finalising explicit criteria for classifying high-risk services which will have to comply with Australian Health Standards in the first phase of implementation.
 - Prospective mapping of standards.
- National Framework for Quality
 - Identifying the best practice elements of quality frameworks and advising Health Ministers on compliance requirements for quality improvements by health services.
- Assessment of bodies
 - Authorising assessment bodies to assess against Australian Health Standards and awarding national accreditation certification.
 - Facilitating and formalising mutual recognition agreements between authorised assessment bodies.
- Data collection and analysis
 - Determining reporting guidelines for health services and authorised assessing bodies, including data elements, definitions, timing and frequency of data to be collected.
 - Collating and analysing data from authorised accreditation agencies.
 - Collating and verifying safety and quality accreditation data with information and trends from data sets.
- Monitoring and reporting
 - Complying with Australian Health Standards.
 - Implementing the National Framework for Quality Improvement.
 - Performance against the Australian Health Standards.
 - Supporting accreditation research.
- Communication
 - Managing public reporting on the outcomes of accreditation and the safety and quality of the health system
 - Developing information for consumers on accreditation.
 - Establishing a website listing authorised assessors and health services that are accredited.
- Appeals
 - Providing a mechanism for health services to seek review of recommendations and accreditation decisions.

1.11 Formal obligations to comply and consequences of non-compliance

The Commission believes that compliance with Australian Health Standards should be mandatory and that all health services be required to accredited against them.

Interest in formal obligations

Throughout consultation on an alternative accreditation system, the Commission has flagged the potential for a mandatory accreditation scheme including formal obligations to comply with accreditation requirements and consequences for non-compliance. The Commission and a number of stakeholders consider that establishing formal obligations achieve better safety and quality outcomes from the health sector's investment in accreditation. For example, throughout the consultation process, some stakeholders have recommended a regulatory-based approach and a significant proportion of stakeholders have expressed support for consequences for non-compliance and an accreditation system with mandatory standards.

Possible mechanisms to implement formal obligations

Regulation can be considered along a spectrum, from self-regulation to formal compliance obligations, or in a regulatory pyramid, as suggested by Braithwaite et al (2005).

A Regulatory Pyramid of Sanctions
Source: Ayres and Braithwaite 1992: 35

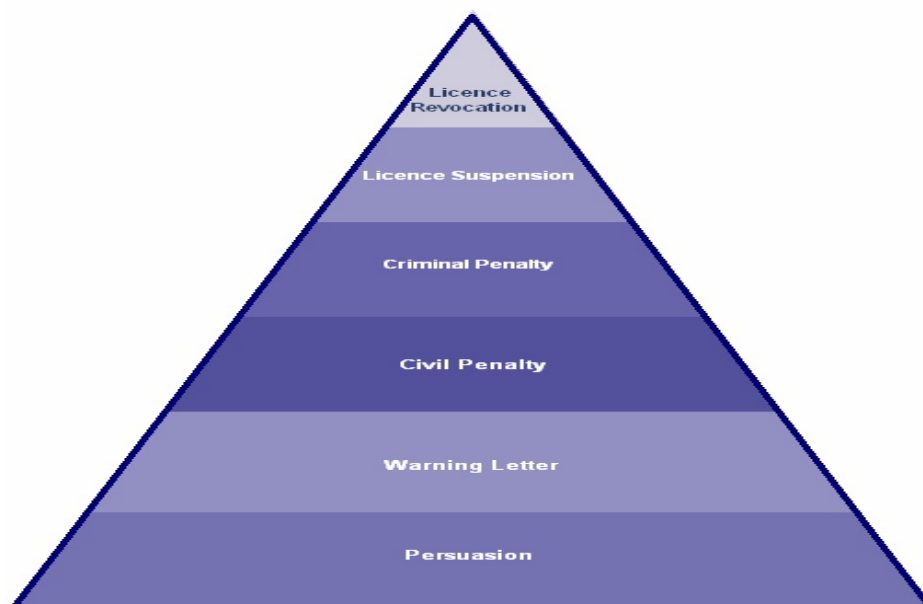


Figure 1:
Source: Braithwaite J, Healy J, Dwan, K. The governance of health safety and quality, Commonwealth of Australia, 2005.

At the base of the pyramid, self-regulatory mechanisms include voluntary accreditation such as that developed by some allied health professions. At the apex of the regulatory pyramid are requirements applied through legislation or attached to funding access.

Current regulation of accreditation

Accreditation is currently subject to quasi-regulation. Many health providers are required to:

- accredit to access Medicare payments
- accredit by their governing body e.g. health service owners or State Health Departments may require the services they administer to undertake accreditation,
- accredit to access funding, e.g. health funds requiring health services to be accredited before benefits are payable.

Establishment of mandatory accreditation and formal obligations to comply with Australian Health Standards

In addition to the existing quasi-regulatory mechanisms, organizations such as medical specialist colleges or professional associations could require compliance with the AHS and QIF as a condition of membership. It may be possible for compliance with the AHS and QIF to be required by health professional registration boards, and there may be potential to introduce or formalise such requirements through the establishment of the national registration scheme.

The Commission does not control the mechanisms that could establish a mandatory requirement for health services to be accredited against the AHS and/or formal obligations to comply with AHS and QIF. However, as an independent national body charged with improving the safety and quality of health care, the Commission could for example recommend regulating bodies, through Health Ministers or funding bodies including states, territories, Commonwealth and private health insurers to establish formal obligations to comply with AHS.

Requirement for all high risk services to be accredited against the NHS

As discussed at 1.4, many high risk services are already required to be accredited, under funding agreements, contracts with private health insurance funds or as a result of policy decisions by governing bodies. For example, health insurance companies require many service providers to demonstrate they are accredited as part of their enrolment. However, there are some high risk service providers that are not captured through existing mechanisms. Therefore, regulatory mechanisms to ensure national mandatory accreditation of high risk service providers may need to be pursued.

The Commission does not have any responsibility for the mechanisms that could achieve a requirement for all high risk services to be accredited against the AHS. As mentioned above, Health Ministers may wish to consider whether a mechanism to mandate accreditation of high risk services should be identified in the establishment of the National Entity, subject to satisfying a cost-benefit analysis and other necessary impact assessment. In the meantime, the Commission urges organisations with responsibility for relevant mechanisms to consider their use to extend accreditation to all high risk services. In finalising its recommendations to Health Ministers, the Commission will liaise with the owners of control levers, such as the Private Health Insurance (PHI) rules, to ensure that high risk groups are appropriately covered without duplication.

Requirement to comply with the AHS – the notification approach

The Commission's preferred initial approach to establishing a requirement to comply with the AHS is to:

- Strongly advocate the need for formal obligations to comply with AHS and QIF and consequences of non-compliance.
- Introduce formal obligations in a supportive way, giving services reasonable opportunities to comply before consequences are applied.
- Balance the consequences of failure to comply against the right of consumers to access safe and good quality services.

The Commission's proposes is that:

- Where accrediting bodies identify non-compliance, they are required to negotiate with the service to achieve compliance, notify the *National Entity* of the non-compliance and progress to resolve the issue.
- If compliance cannot be achieved within an agreed period to be determined in the development of the Australian Health Standards and QIF, the accrediting body is required to notify the *National Entity*.
- The *National Entity* will investigate (this may include seeking independent peer review) and will negotiate directly with the service to achieve compliance within an agreed timeframe depending on the issue and urgency.
- Should compliance not be achieved, the *National Entity* will publish details of the issue on its website and notify relevant bodies such as owner, governing bodies and funders.
- Accrediting bodies would agree to inform the *National Entity* about non-compliance with the AHS and QIF as part of their authorisation to assess against the AHS.

The notification approach to oblige compliance with AHS and QIF is a light touch compliance approach focused on achieving compliance as quickly as possible. The Commission believes that this approach will create a learning culture and simultaneously create an understanding of formal obligations. Many stakeholders have sought a balance between these priorities, however bodies which control mechanisms that could establish formal obligations more directly may wish to consider approaches to further embed the formal obligations. The Commission will support such developments, and is liaising with DOHA in relation to the implementation of AHS through the PHI rules, which would achieve their application to a range of high risk services.

If the notification approach is not successful in achieving compliance and Health Ministers agree, a regulatory-based approach could be explored through the development of a Regulatory Impact Statement. Alternatively, Health Ministers may wish to consider whether a regulatory mechanism to mandate compliance with the AHS should be progressed in the establishment of the National Entity, subject to satisfying a cost-benefit analysis and other necessary impact assessments.

Sanctions and Penalties

As the long term objective is to implement a mandatory system of accreditation, it will be necessary to consider the sanctions that could apply. Stakeholders did not support a simple pass/fail system, but recognised the need for sanctions, which were graduated and escalating, to apply to services that fail to meet the standards. It has been recommended that sanctions be based on ‘a pyramid of responsive regulation’ as described by Ayres and Braithwaite³ (see above). This approach promotes transparency and professionalism by:

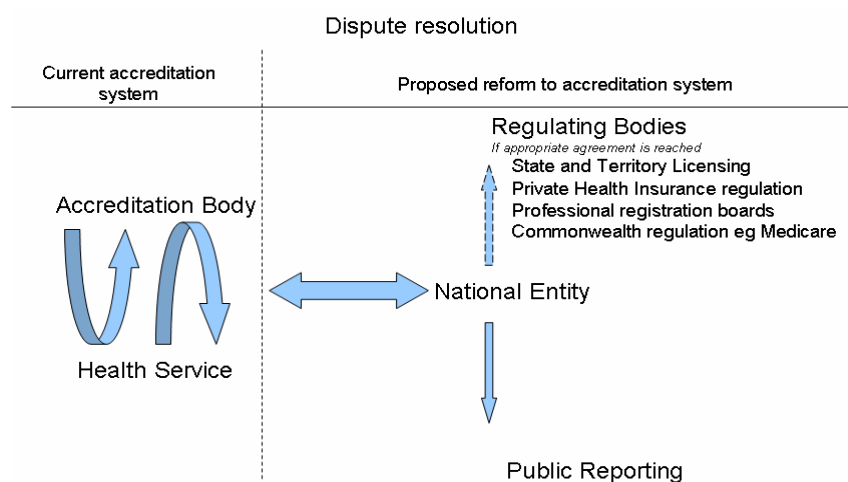
- Requiring persuasion as the first approach.
- Using increasingly strong regulatory mechanisms to encourage compliance if persuasion is unsuccessful.

The notification approach will start with persuasion moving to a warning from the *National Entity* and culminating in the *National Entity* making public details of non-compliance. If appropriate agreement cannot be reached, the matter may be sent to the relevant regulating body to investigate, e.g. under licensing legislation.

In determining the application of consequences the following matters could be taken into account:

- a single issue or more widespread poor performance
- non-compliance related to a minor or serious breach
- a breach that has occurred for the first time or has occurred before
- a breach which threatens the health, welfare or interest of consumers
- any element of deliberate non-compliance.

The *National Entity* will endeavour to resolve a dispute between the health service and the accrediting body. Where the *National Entity* is satisfied that there has been a significant failure to meet AHS or a continuing failure to meet a standard, after provision of an opportunity to do so, the NE will publicly notify the failure and, if appropriate, inform any relevant body. This process is outlined below.



³ Ayres, I and Braithwaite, J (1992) *Responsive Regulation: Transcending the Deregulation Debate*, New York, Oxford University Press.

Application of sanctions

A call for jurisdictions to retain responsibility for sanctions and penalties was made in the AHMAC proposal and in separate State submissions. This option is retained in the *Alternative Model's* notification approach. Mechanisms already exist for dealing with civil penalties and criminal penalties which would not be duplicated in this model. Further embedding the formal obligations, for example, through licensing legislation would be a matter for jurisdictions.

A number of professional groups called for sanctions to be applied through professional registration boards. Mechanisms do not currently exist to empower registration boards to apply sanctions for failures by health services to comply with accreditation standards. The *National Entity* and National Registration Boards may wish to give this further consideration in the development of the national professional registration scheme.

It is not proposed that sanctions be imposed on health services in relation to the Quality Improvement Framework.

Incentives

Health services have called for incentives, such as those offered to general practitioners, to comply with accreditation requirements. However, funders note that provision of safe services and quality care is core business for health services and should not be subject to incentive payments. The Commission's general position is that the best practice that will be reflected in AHS and the QIF should be adopted by health services in their normal operation and additional incentives should not be required.

APPENDIX 1

Principles for Improvement of the Safety and Quality Accreditation System

Developed by the Australian Council on Safety and Quality in Health Care in 2003.

1. Stakeholder confidence in the rigour of accreditation systems and the reliability of responses to significant non-compliance is enhanced.
2. Accreditation of health care services is supported. Varying regulatory and funding options for achieving greater national consistency are utilised to encourage accreditation of health care services.
3. Effective consumer engagement occurs throughout the accreditation system.
4. The administration of accreditation is efficient.
5. Standards against which compliance is assessed are capable of adaptation to varying health environments – but are firm and credible.
6. Surveying against standards is credible, robust and consistent.
7. Accreditation processes encompass both assessment of compliance with minimum standards and encouragement of continuous improvement.
8. Standards setting and accreditation processes are externally validated.
9. Assessment options are flexible.
10. Responsibility for taking action on accreditation outcomes is clearly defined.
11. Accreditation processes and outcomes are transparent.
12. Information learned from accreditation is used for system wide improvement.
13. The direct and indirect relationship between accreditation and safety and quality in health care is evaluated through research.

APPENDIX 2

ISQua International Accreditation

The following information was accessed from the ISQua website:

<http://www.isqua.org.au/isquaPages/General.html> accessed on 30 October 2007.

ISQua provides international programs based on best international practice standards and principles to assess, survey and accredit in the areas of

- standards,
- organisational performance,
- surveyor/assessor training programs, and
- education and learning programs in quality and safety in health care.

ISQua Accreditation is an external evaluation and recognition award based upon a four-year cycle of

- assessment tools and guidance,
- supported development, education and training,
- self-assessment and documentation review,
- on-site pre-survey review,
- independent peer assessment or on-site survey,
- full report and recommendations for improvement,
- accreditation as a formal recognition of achievement, and
- opportunities for on-going development.

ISQua International Accreditation Program Fees

Access Fee: US \$1,200

(information package for ISQua Standards Assessment is sent on receipt of payment)

Standards Assessment: US \$2,180 per annum

(fee for service paid via equal instalments over 4 years)

Training Program Assessment: US \$1,900 per annum

Organisation Survey: US \$2,780 per annum

Organisations with standards: US \$4,900 per annum

(includes on set of standards)

Organisations using standards developed by another body: US \$3,700 per annum

Additional standards US \$1,000 to annual fee

APPENDIX 3

JASANZ Accreditation

The following information was accessed from the JASANZ website:

<http://www.jas-anz.com.au/> accessed on 30 October 2006

JASANZ accepts applications for accreditation from Conformity Assessment Bodies in the areas of Management Systems Certification (General Practice Accreditation Scheme and Hospital Accreditation Agencies Scheme), Product Certification, Personnel Certification and Inspection. Accreditation involves five general steps and involves reassessment every four years:

1. Application – submission of application form and payment
2. Systems Assessment – review of documentation against accreditation criteria and report provided back to applicant
3. Assessment – Onsite assessment by team and completion of report with recommendations
4. Review of Assessment Report – JASANZ Accreditation Review Panel review report and make accreditation decision
5. Accreditation Decision – Certificate of Accreditation issued if accreditation is approved. If accreditation is not granted applicant advised of reason.

Regular visits occur to assess ongoing compliance with accreditation criteria.

JASANZ Fees

(Australian Dollars)

Application fee: \$2000

(Covers 1 day document review, \$125 invoiced per hour for additional reviews)

Program Fee for Management systems: \$10,000 per annum (invoiced monthly)

Certificate Fees: Vary for per number of certificates issued per annum, and details are available on the website.

THIS PAGE INTENTIONALLY LEFT BLANK