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SUBMISSION
Commonwealth Parliamentary Inquiry into Health Funding

The Australian Council on Healthcare Standards (ACHS) would like to submit the following information relating to term of reference (c) of this inquiry:

> *c) considering how and whether accountability to the Australian community for the quality and delivery of public hospitals and medical services can be improved*

INTRODUCTION

There are several ways in which the process of accreditation of health services can improve accountability to the Australian community. The following submission will outline how

1. the accreditation process itself
2. the participation of consumers in the accreditation process
3. the reporting of accreditation results by a health service to the community
4. the reporting of aggregated national accreditation results by the ACHS and
5. the reporting of clinical indicator performance data

can all improve accountability for the quality of care and services that a health care organisation provides.

THE ACCREDITATION PROCESS

Accreditation is defined as *"a status that is conferred on an organisation that has been assessed as having met particular standards. The two conditions for accreditation are an explicit definition of quality (ie standards) and an independent review process aimed at identifying the level of congruence between practices and quality standards."* [1] [2]

The ACHS Evaluation and Quality Improvement Program (EQuIP) provides organisations seeking accreditation with a four year program which includes Self-Assessment, Organisation-Wide Survey and Periodic Review and the development of a

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[1] Australian Institute for Primary Care Centre for Quality in Health and Community Services. The evidence for effectiveness for quality initiatives in human services. A critical review. November 2001, Page 15

[2] Accreditation embodies the term certification

Quality Action Plan. Accreditation is awarded when it has been demonstrated that the organisation meets ACHS standards.

Standards for organisational development, evaluation, assessment and accreditation are determined in consultation and collaboration with health care professionals, consumers, government and industry stakeholders. These standards are widely reviewed and subjected to rigorous pilot testing so that they reflect contemporary best practice principles and are achievable and measurable. The standards are industry specific and applicable to all health sector organisations including hospitals, aged care facilities, day procedure centres, community health services, multipurpose services, corporate offices, professional colleges and associations. The principles underpinning ACHS standards are all consumer / patient focused and cover an organisation-wide approach to include evidence of outcomes, strong leadership, a culture of improving and striving for best practice.

After 22 years of providing health service accreditation, the ACHS increased the level of accountability of health services by changing its accreditation program. In 1996 the ACHS altered the program from a once every three year onsite review to requiring health services to commit to the cycle of annual events of onsite review or self-assessment described above, in order to maintain their accreditation status. The standards now also require the demonstration of outcomes, rather than compliance to the presence of a list of structures and processes.

In January 2003, in response to concerns in the health industry about the rigour of ACHS accreditation and its capability to keep consumers safe, EQuIP 3rd edition was introduced with a greater requirement to ensure quality and safe care and service. The ACHS achieved this through the introduction of mandatory criteria.

There are 43 criteria in the EQuIP 3rd edition, 19 of which are now mandatory. These 19 were considered by health industry stakeholders to be the most important of the 43 for the delivery of quality and safe care in the current safety and quality agenda for Australia. They were determined with input from the Australian health care industry through a field review and piloting process as well as major stakeholder reviews. At least in these 19 areas of practice, organisations and surveyors need to be confident that systems are well established and that they are performing how they were meant to perform, that is, the systems are evaluated. In order to achieve or retain accreditation status a rating of Moderate Achievement (MA) or higher is required in these 19 mandatory criteria.

The ACHS assists health services in both the public and private sector to be accountable to the Australian community for the delivery of quality and safe care. An organisation seeks ACHS accreditation to demonstrate that it is dedicated to providing safe and quality care and / or services; committed to continually improving

what it does; and has the necessary systems and processes in place to achieve desired outcomes.

PARTICIPATION OF CONSUMERS IN THE ACCREDITATION PROCESS

The ACHS standards require health services to plan and deliver care in partnership with the consumer as well as ensuring participation of consumers in the planning, provision, monitoring and evaluation of the health service. This consumer participation assists health services to be more accountable for the delivery of safe, quality care.

Consumers are also included in all survey teams of mental health services. Experience has shown that the consumer perspective in the reviews is invaluable in ensuring a comprehensive review of the quality of care provided by the heath service. The participation of consumers in survey teams of all health services would increase accountability for quality care. However, although it is possible for the ACHS to include consumers in teams, health services are unable to bear the additional cost.

REPORTING HEALTH SERVICE ACCREDIATION RESULTS

The ACHS believes that accountability of health services, both public and private, for quality and safe care can be improved through the public disclosure of the results of accreditation by the health service. Following an accreditation survey, the health care organisation (HCO) that has been surveyed is provided with a comprehensive report of the results of that survey against the many standards and criteria. The report also contains commendations and recommendations for improvement. The HCO is then required to develop a Quality Action Plan that addresses the recommendations. At present, there is no requirement for health services to disclose the content of their accreditation report or their Quality Action Plan. It is ACHS policy to encourage health services to publish their accreditation report or a modified statement of accreditation performance either on their web site or on the ACHS web site. Few organisations do so; understandably organisations that have received a very positive report are generally happy and willing to do so.

REPORTING NATIONAL RESULTS

A further mechanism for improving the accountability of health services for quality is through the public reporting of aggregated nation accreditation performance data.

On 23rd June 2005 the ACHS will release the first *ACHS National Report on Health Services Accreditation Performance*. On 31 December 2004 more than 950 Australian health care organisations were participating in The Australian Council on Healthcare Standards (ACHS) accreditation programs. The report provides data on and analysis of the results of accreditation surveys conducted by the ACHS in 674 Australian health

care organisations during 2003 and 2004. The ACHS accredits 63% of public hospitals, 74% of private hospitals and 67% of total hospitals in Australia. These figures represent 84% of public beds, 94% of private beds and 87% of total available beds in Australian health services.[3] 54% of ACHS members are private organisations, 44% are public health care organisations; all states and territories are represented in the membership.

The report contains many interesting analyses, all of which will establish a new level of accountability in Australian health services. Among other findings the report notes that the percentage of health services that gained full four year accreditation dropped from 81% in 2002 to an average 35% in 2003 and 2004 with the introduction in 2003 of a mandatory level of performance in 19 criteria in order to achieve full accreditation.

The report reveals that there are several important areas that need considerable improvement:

- Proven systems to effectively identify, report and manage risks across the organisation were identified as inadequate (and allocated a Some Achievement (SA) rating) in 341 of the 674 organisations (51%)
- In 173 organisations (26%) the emergency management systems required attention to ensure that they were adequately protecting patients and staff (SA rating)
- In 114 of 244 organisations (47%) recommendations for an SA rating were given to improve the way they managed the performance of all their staff to ensure they had the skills and competence to deliver quality and safe care and service
- Ten organisations lacked formalised systems (and were allocated at least 1 Little Achievement rating) for an organisation-wide approach to managing risks and to manage specific risks to the information technology systems. Formal systems for incorporating legal requirements into practices, for patient assessment, infection control, staff health and safety, manual handling were also required
- Patient care was considered compromised (as indicated by the allocation of High Priority Recommendations) in 8 organisations because of the lack of formal clinical processes relating to medical staff availability, credentials and competencies of staff, appropriate resources to perform the clinical service, clinician involvement and responsibilities in care delivery, for example in the consent process
- Patients, visitors and staff were at risk, with a High Priority Recommendation being made in 10 organisations because of inadequate attention to fire safety.

This report provides information for the community, health care providers, funders and policy makers. The intention is to report on the accreditation performance of health services every two years. Trends in performance will continue to become more evident with the accumulation of data. Further, comparisons will be possible on the performance of the same cohort of organisations that participate in an Organisation-Wide Survey in

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[3] AIHW (Australian Institute of Health and Welfare) 2004. *Australian Hospital Statistics, 2002-2003*. AIHW cat no HSE 32. Canberra: AIHW (Health Services Series no. 22)

2003 and then a follow up Periodic Review in 2005. Several aspects of performance were unable to be analysed for this report. These include whether and how well organisations use the survey recommendations to improve care and service and whether this is able to be demonstrated in an appropriate clinical indicator. It is hoped that these will be included in future reports.

The continued aggregation and trending of these accreditation data for the vast majority of health care services, private and public across Australia, will provide an ongoing commentary on safety and quality for Australian health care consumers.

REPORTING CLINICAL INDICATORS

A complementary approach to improving accountability would be a requirement for greater reporting of information on safety and quality. Health services have the opportunity to collect any of 245 ACHS clinical indicators across 20 clinical specialty areas. The indicators are developed in association with the medical colleges and other professional associations and are regularly reviewed. One hundred and forty-eight (148) of these indicators are directly related to patient safety. Member organisations choose the ACHS indicators they consider are most useful to monitor the care of their patients. They submit the data to the ACHS every six months. The ACHS analyses the data and provides a report back to each organisation on its performance compared to the national data and where relevant, to their peers. This Comparative Report Service allows an organisation to review its own performance in comparison with other services and where there are unexplained differences, to review in detail their practices to determine if changes are necessary to provide better quality and safer care to their patients. Any requirement for national reporting on safety and quality outcomes needs to retain a focus on the internal use of data so that care is made safer for consumers rather than being collected for reporting purposes.

Some trends can be identified in ACHS clinical indicator data in the 6 years from 1998 to 2003. There was statistically significant deteriorating performance in

- Emergency Department Triage categories 2-5
- vaginal delivery after primary caesarian sections
- access to radiation oncology for waiting times of more than 21 days
- post operative pulmonary embolism in patients with length of stay > 7 days.

Reporting of clinical indicator data in ACHS accreditation is currently not mandatory within the program and the focus is on the use of information for improving services. The Australian Council for Safety and Quality in Health Care's Working Group on Standards and Accreditation Framework proposed "improved reporting of performance" by encouraging governments to require accreditation agencies to report performance of organisations undergoing accreditation surveys with the consent of the organisation. The Working Group suggested these data could be collated and used:

- for public reporting;
- to identify areas for system wide improvements
- to determine future directions for standards development
- by other bodies with an interest in safety and quality of health care[4]

The ACHS first report on accreditation performance mentioned above responds to the proposal.

MANDATORY ACCREDITATION?

Given that accreditation is one approach to ensuring accountability for safe, quality care, the question of mandating accreditation needs to be considered. The Australian Council on Safety and Quality in Health Care Working Group on Standards and Accreditation Framework considered in detail the "balance between self-regulation and enforced compliance" [5] and recognised the challenge "to devise a system that incorporates both appropriate incentives for self regulation and a range of effective remediation strategies, within a framework that allows flexibility of response depending on specific circumstances and preferences". The Working Group considered that "in the absence of a base of firm evidence linking accreditation to improved safety and quality of care, a recommendation that all organisations be required to be accredited would be inappropriate." The Standing Committee may be interested to note that the Centre for Clinical Governance Research in Health, UNSW and industry partners ACHS, Affinity Health, Ramsay HealthCare, with contribution also from the Australian Health Insurance Association, were awarded an Australian Research Council (ARC) linkage grant in November 2004 to examine the relationship between accreditation and organisational and clinical performance. The results of this research will have international significance.

The ACHS accreditation program began in 1974 with voluntary participation and was based on the principle that accountability of health services for safe, quality care was best achieved through a program that encouraged continuous improvement to meet standards, with appropriate support and advice. The counter view was for mandatory participation in accreditation with rigorous requirements for compliance. The ACHS has always argued that mandatory participation could result in organisations doing the minimal amount to meet requirements rather than striving continually to provide the optimal standard of care.

However with a greater awareness of the need for safe, quality care in the community, the current ACHS program has combined a more rigorous approach to standards and to their assessment and a "higher bar" to jump to gain accreditation status, while still

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[4] Australian Council for Safety and Quality in Health Care. Standards Setting and Accreditation Systems in Health: Consultation Paper. July 2003. www.safetyandquality.org

[5] Australian Council for Safety and Quality in Health Care. Standards Setting and Accreditation Systems in Health: Consultation Paper. July 2003. www.safetyandquality.org

providing access to support and advice and "re-survey" as stimuli to continuous improvement.

Accountability can be improved by ensuring data on safety and quality are used by health services and health service funders to improve systems that are performing below standard. Performance in accreditation surveys can be used to identify specific areas where resources could be concentrated to improve the ability of health services to provide safe, quality care. For example, from the data presented above, resources could be targeted to address:

- building infrastructure and repairs (eg inability to implement recommendations from fire reports), buildings and equipment not meeting codes or standards to deliver the required level of care (eg high priority recommendation for care being compromised)
- workforce for direct care delivery (eg deteriorating performance in Emergency Department Triage Categories 2-5, access to radiotherapy treatment)
- programs for staff training and performance management systems to ensure staff skills and competence made low priorities with rising demands for direct clinical care (eg inadequacy of performance management systems)
- lack of leadership and management skills to successfully implement organisation-wide systems for managing risks (eg inadequate risk management systems)

CONCLUSION

The ACHS believes that many aspects of accreditation provide a means of ensuring the accountability of health services for safe, quality care. ACHS accreditation data on the performance of the large majority of Australian health services can be used to develop specific strategies and provide resources to target areas of poor performance identified by these data.

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1 June 2005