



Professor Margaret Banks  
Policy Team Leader  
Australian Commission on Safety and Quality in Health Care  
GPO Box 5480  
SYDNEY NSW 2001

Dear Margaret

Thank you for the opportunity to provide a response to the Australian Commission on Safety and Quality in Health Care's Consultation paper on National Safety and Quality Healthcare Standards. Our submission focuses on the issues arising for the private hospital sector from the implementation of national standards. Some APHA members have provided comment on the detail of the standards themselves.

APHA understands that piloting of the draft Standards will begin later this month. APHA looks forward to being involved in this process and being kept informed of progress.

As you are aware, APHA is the peak national body representing the interests of the private hospital sector, with a diverse membership that includes large and small hospitals and day surgeries, for profit and not for profit hospitals, groups as well as independent facilities, located in both metropolitan and rural areas throughout Australia. The range of facilities represented by APHA includes acute hospitals, specialist psychiatric and rehabilitation hospitals and also free-standing day hospital facilities.

Current accreditation is a condition of membership of APHA.

Please contact me if APHA can assist the Commission further on this important matter.

Yours sincerely

A handwritten signature in black ink, appearing to be 'M. Roff'.

Michael Roff  
CHIEF EXECUTIVE  
February 2010

**RESPONSE BY THE  
AUSTRALIAN PRIVATE HOSPITALS ASSOCIATION TO THE AUSTRALIAN  
COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE'S CONSULTATION PAPER  
ON  
NATIONAL SAFETY AND QUALITY HEALTHCARE STANDARDS**

**Background**

In April 2008, after an extensive consultation process amongst stakeholders conducted by the Australian Commission on Safety and Quality in Health Care ('the Commission'), the Australian Health Ministers' Council endorsed a model for safety and quality accreditation that had been recommended to them by the Commission. APHA was involved in these consultations and made a written submission in response to the Commission's Discussion Paper.

The Commission then set up an Implementation Group to assist with the task of developing national standards and planning for implementation. APHA is represented on that group.

**Overall Comments**

APHA agrees with and supports five draft Standards and the areas addressed within them. The standards are very similar to those that are contained within the Evaluation and Quality Improvement Program (EQuIP), administered by the Australian Council on Healthcare Standards (ACHS) and the ISO 90001 Healthcare Standards, which are used by private hospitals to meet their accreditation requirements.

APHA is concerned that there is still no commentary on how it is proposed that these standards will be implemented in relation to existing systems of accreditation. As the paper stands, it can only be assumed that these National Standards will sit alongside existing standards, and that hospitals will need to comply with both. It would be desirable for the Guidelines and Tools referred to Section 5 of the Paper (page 6) to be released as soon as possible, and to make explicit how it is intended that the national standards function as an accreditation mechanism. Please also see our comments in response to Question 9 of the Consultation Questions below.

In previous submissions and comments to the Commission, APHA has emphasised that there is insufficient recognition of the significant costs imposed on hospitals by the duplication and overlap of the current regulatory environment around quality assurance. Accreditation is but one part of regulation. APHA is most concerned at the ever increasing costs of compliance imposed on private hospitals to meet the requirements of State licensing; State-based safety and quality bodies such as the Queensland Health Quality and Complaints Commission; and private health insurance funds, in addition to accreditation agencies, all of which are seeking to undertake the same task, assuring the safety and quality of health services.

For example, ACHS has a mandatory standard for credentialing, the Queensland Private Health Facilities Act 1999 has a mandatory Credentialing and Clinical Privileges Standard, each of the health insurance funds require compliance with, and reporting on, standards for credentialing and the Queensland Health Quality and Complaints Commission also has a mandatory standard for Credentialing. All of these have different reporting requirements. This is wasteful and inefficient and is but one of a plethora of overlapping requirements imposed on private hospitals for no clear outcomes in patient safety and service quality.

This situation can be described as one of “safety and quality arbitrage”, where the various parties tout their safety and quality reporting systems as more comprehensive, rigorous and superior. However, unless positive patient outcomes can be demonstrated, more and more reporting does not equate to better safety and quality. APHA is therefore opposed to giving the States and Territories any capacity to extend or add to the national standards.

APHA notes the Commission’s comment that a National Coordinating Body should be set up to ensure the “consistent assessment” of the National Standards. We believe that before such a body is set up, a decision must be made on whether the National Standards are going to be the single set of Australian standards.

It has long been APHA’s view that the safety and quality of health services is a shared endeavour, to be undertaken by providers (institutions and practitioners), funders and governments with the objective of providing optimal outcomes for consumers/patients. We believe that the National Standards and their implementation should be introduced in this framework of shared responsibility.

### **The Commission’s questions**

APHA’s comments against each of the questions posed in the Commission’s Discussion paper are set out below.

#### **1. Is the language and format of the NSQH Standards appropriate?**

APHA notes that the draft Standards, in some instances, use different descriptors and nomenclature from that used in other accreditation programs. This could be confusing for hospitals. We suggest that this be given particular attention in the pilot phase. Again, we make the comment that it is important for hospitals to know as soon as possible how, or if, these national standards will fit in with other accreditation regimes.

Specifically, APHA suggests that the reference to “clinical guidelines or pathways that are supported by best available evidence” in the Clinical Governance Standard (SQ B 1) immediately raises the question of who is to be the arbiter of the “best available evidence”. This standard will be very difficult to implement unless the Commission gives specific guidance around this aspect.

Also in relation to SQB1, APHA believes that the reference to “patients at increased risk of *harm* from health care” (emphasis added) is confusing. Arguably, no patient who is going to be actively harmed by it should receive a treatment or undergo a procedure. We suggest that this be phrased simply as “patients at increased risk....”

**2. Are there gaps in the NSQH Standards that should be addressed?**

APHA notes that there are no outcome measures listed for the Standards. The focus appears to be on process. Processes, however excellent, cannot of themselves lead to safety and quality. APHA would like to see some outcome measures by which achievement could be benchmarked. APHA notes that the Commission acknowledges this (page 3) and refers to “locally relevant outcomes data”. This is a very broad phrase, and APHA urges the Commission to give further consideration to some basic, nationally consistent outcome measures.

**3. Are there unnecessary items or duplications that should be removed from the standards?**

See the comments above in relation to system-wide duplication of standards.

**4. Is the level of detail provided adequate to implement the standards?**

**5. If not, what additional information is needed?**

APHA believes that these aspects will be best tested in the pilot phase. See also the comments above in regard to duplication with existing accreditation and mandatory reporting systems and the timely provision of implementation guidelines referred to in the Consultation paper.

**6. Are there settings in which some of the elements of individual standards do not apply?**

APHA does not think that there are settings to which the standards should not apply. However, it is not readily apparent how the standards will apply to psychiatric services, both in-hospital and out-reach services.

**7. Are the process measures in individual standards appropriate for the assessment of safety and quality of each of the elements?**

The measure in Clinical Practice section of the Governance Standard (SQ B 1) should be strengthened. It is difficult to imagine that any HSO would not include safety and quality in its induction programs. However, this is a long way from “developing and applying clinical guidelines or pathways that are supported by best available evidence”. The process measure should require evidence that such guidelines and pathways are disseminated and adhered to.

See also the comments in response to Question 1 above.

APHA agrees with other comments to the effect that Item F of the Governance Standard appears superfluous.

**8. Can the draft NSQH Standards be applied in your healthcare setting without modification?**

Again, only the pilot will demonstrate this for individual hospitals.

**9. Should the final set of NSQH Standards be the only safety and quality requirements for accreditation or should jurisdictions and/or accrediting agencies have the capacity under the new model to add further safety and quality requirements to accreditation?**

APHA believes that the NSQH Standards should be the only safety and quality requirements. For the reasons stated in the opening paragraphs above, APHA is opposed to any new requirements being added by any jurisdiction. The regulatory compliance burden on the entire hospital sector, public and private, is too heavy as it is, with insufficient focus on outcomes and far too much emphasis on process. If the States and Territories or any other party, are allowed to impose additional requirements, they will do so in the name of “enhanced” safety. The losers here are the patients, as scarce resources are diverted to administration.