



# A Review of Quality Improvement Approaches in Health and Community Services

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Every effort has been made to ensure the accuracy of the information contained in this report, but any errors are of course the responsibility of the authors.

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# Executive Summary

## Background

Experience from the field indicates that quality frameworks for primary health and community services are changing rapidly. New standards and quality assurance and review processes have been developed for a range of program areas including multipurpose services, mental health, residential and community aged care and maternal and infant care services. Recently there has also been interest in the application of quality improvement, quality assurance and accreditation to health promotion and public health programs. In part this reflects the general trend toward benchmarking, evidence-based practice, best practice and outcomes-based funding in an environment where funders are increasingly becoming purchasers and contract managers.

As a result, there is now a potential for a proliferation of approaches to quality improvement, quality assurance and accreditation. Simultaneously, primary health and community services are under pressure to improve continuity of care and coordination in the interests of better client outcomes. As agencies are increasingly required to adhere to quality frameworks and report on performance systems for a greater diversity of programs, transaction costs are likely to increase.

It is timely to review commonalities and differences in quality frameworks which have developed for primary care and community services and local agencies responsible for the provision of public health and health promotion programs.

The Quality Improvement Council (QIC) sought funding from the Commonwealth Department of Health and Aged Care for a project to review quality improvement approaches in primary health and community services. These services include, but are not limited to, community health services, alcohol and drug agencies, home and community care services, disability services and mental health services. The review did not consider general medical practice. Accreditation issues for this sector have been extensively canvassed previously and a highly specific and self-contained system of quality assurance and accreditation for this sector has evolved separately.

The current project aimed to:

- review and compare the characteristics of available frameworks on quality improvement and quality assurance which are relevant for primary care and community services;
- obtain stakeholder views (providers, funders, reviewers) of the important factors that should be taken into account in the development and implementation of primary health and community services quality improvement and assurance processes;
- review the available evidence from the QIC Program on the performance of agencies using QIC standards and review processes; and
- produce recommendations to influence the ongoing development of a quality framework for this sector.

## Literature review

The published literature and available documents on quality systems for primary care, community services and health promotion and local public health services were reviewed to compare and analyse the characteristics of quality improvement approaches. The review informed the consultation and provided a comprehensive conceptual framework for analysing approaches to quality improvement, assurance and accreditation in these areas.

The literature review is available as a separate document however a summary is provided in this report.

The literature review concluded that although there were a variety of quality programs in the health and community services sector, ACHS and QIC are the major players. These quality programs have an advantage in establishing ownership of their programs through the development of health specific standards in consultation with the sector.

There is now increasing pressure to move from structure and process standards to more outcome orientated standards to improve the measurement of outcomes to communities and individuals. Although this has occurred to some extent in the acute sector, it is timely to reexamine the issue of outcome standards for the non-acute sector. There are also moves to more actively involve consumers in quality processes, particularly in the evaluation of services.

The development of multipurpose services, and the amalgamation of community health and hospital services in particular, raises concerns around overlapping demands for the implementation of a variety of standards within a single agency. Proliferation of standards and confusion and duplication across quality programs must be addressed and appropriate protocols need to be developed between quality program providers.

Overall, the literature review concluded that organisations that developed standards and accredit agencies in the health and community services sector strive for continuous quality improvement and to develop optimal standards. The agencies that develop standards specific to health care, however, are more likely to have optimal standards than the more generic accreditation programs, as they can address issues of particular relevance to the sector. To maintain and strengthen this advantage it is important to have key stakeholder interests involved in the continuing development, review and assessment of standards.

The future direction of accreditation in Australia is likely to see agencies broadening their scope to become more competitive. This shift must also involve consultation between agencies to ensure accreditation in Australian health care is efficient, comprehensible and consistent.

## Data analysis

The QIC national database on accreditation reviews for health and community services agencies was used to investigate agency performance against QIC standards. The QIC database has been extensively redeveloped since 1998. As the major quality program provider to the non-hospital health sector, the QIC database provides an important resource which can be used to examine the performance of agencies against standards, in addition to monitoring the reviewing the standards themselves. Although the current data is limited some broad conclusions can be drawn. Comment is only undertaken where there was sufficient data to justify analysis. In particular the data provides information regarding the two main QIC modules, the Core module and the Primary Health Care module.

There are currently only a small number of agencies represented in the data for some of the modules. It will be important however that as the database develops, it is regularly monitored and the information provided for policy development.

## Agency types

For the analysis, agency type were categorized which had beds, either for in-patients or aged care and those which did not. The majority of agencies reviewed did not have beds.

In general, there was a relatively consistent pattern of performance across standards between agencies with beds and those without. The only exception to this was for the Primary Health Care module where although the figures are still low, agencies with beds met more standards than agencies without beds.

## Program areas

Conclusions regarding agency performance by program areas such as drug and alcohol are also limited because of small numbers in each program category. This will however be an interesting set of data to monitor in the future as the database develops. For those categories where sufficient data existed to draw preliminary conclusions, most program areas perform relatively consistently irrespective of the module used.

## Jurisdictions

Although there is some variation in performance across the states and the different modules, the database indicates a high level of compliance with standards across program areas, agency types and jurisdictions. In addition, a small percentage of standards are exceeded. This would indicate that the database could be a useful tool for identifying current and appropriate best practice examples for the various modules in most states. The tables indicate that South Australia and Queensland performed better on the Core and Primary Health Care modules respectively, relative to the other states. The figures for standards not met were however consistently low across states and territories. NSW had a particularly high level of standards designated as inappropriate, but only in relation to the Home Based Care module.

## Standards

There was some variation in agency performance against individual standards in both the Core and Primary Health Care modules. However a larger data base would be required to draw more than preliminary conclusions. Few standards were designated as not applicable other than optional standards like those relating to Resource Production and Merchandising which are not undertaken by the majority of services.

### **Recommendation:**

- 1. That regular reports could be provided by accreditation agencies both to assist with monitoring the quality of services in the sector, and in order to contribute to appropriate policy development. The Commonwealth and State governments could have a role in progressing this issue.**

## Stakeholder consultation

The stakeholder consultation focused, in particular, on questions around:

- the importance of standards and their development;
- the role and cost/benefit of accreditation;
- concerns around the delivery of quality programs;
- improvements which could be made to quality programs and barriers to these;
- the specific needs of rural and remote services.

## General issues

The national consultation indicated a high level of support for standards and participation in quality improvement processes. Standards should describe and provide a measuring mechanism for reasonable community expectations around an agency's performance. Quality programs had an important role to play in providing advice and support to agencies that aim to improve the quality of their services using standards, through a process of continuous quality improvement. Ideally participation in a quality improvement program provided an opportunity for services to temporarily step back from direct service delivery and to reflect on their practice relative to their peers.

The role of accreditation was more contentious as some thought it undermined the continuous quality improvement process by becoming an end in itself. Nevertheless, accreditation provides an important confirmation that either a predetermined standard has been reached in a particular service, or that the service is participating in a process which aims to achieve that standard. Participation in a quality program is also an important accountability mechanism for funders.

Although there was strong support for participation in quality improvement processes amongst stakeholders, the consultation also highlighted significant issues regarding standards and accreditation in the health and community services sector.

These included:

- the role of accreditation;
- confusion and duplication about standards and current quality accreditation programs;
- complexity and workload involved in current quality accreditation programs;
- adapting current accreditation programs to changing configurations of agencies (in particular amalgamations of acute and non-acute service provision);
- resourcing issues for those wanting to participate in quality program activities;
- cost/benefit concerns;
- concerns around the quality and appropriateness of current quality programs and their delivery;
- commitment to quality at agency and government level;
- the role of quality assurance in agency accountability and risk management;
- the role of consumers in provision of health and community services;
- the role of government in the development of standards and delivery of quality programs;
- whether standards should be generic or specific, maximum or minimum, process or outcome;
- setting standards for the future, rather than the present or the past;
- information provision, education and training around quality issues.

Confusion about the purposes and costs of participation in quality programs is central to these concerns. The purpose for participation varied from those who were committed as a matter of principle, to those who did so because it was an accountability requirement. Others saw it as

an important response to meet consumer expectations, or as a management tool. Concern about costs included time spent preparing for reviews, the program fees which had to be paid and cost of staff participation as reviewers – which was a particular difficulty for smaller and more remote agencies.

Concerns about the proliferation of standards and the duplication of quality programs and processes were also significant. Providers clearly find that duplication and proliferation add to the costs of participation in quality programs. This is particularly problematic for agencies providing a range of different community and residential or inpatient programs which are covered by different standards and where there are several options for accreditation.

In response to these concerns, there were a wide range of suggestions for improvements to the implementation of quality programs in the sector. Barriers to these improvements were also identified. Recommendations aim to influence the ongoing development of a quality framework for the health and community services sector however they also reflect the current lack of clarity around the appropriate agency that should be responsible for moving this agenda forward. Specific suggestions for improvements and recommendations are outlined below.

#### Cooperation between quality programs

More cooperative arrangements between quality program providers, and in particular QIC and the Australian Council on Healthcare Standards (ACHS), need to be developed.

ACHS and QIC could form a partnership to deliver accreditation and support quality programs across the sector, although this is probably not likely in the short term. Both are non-profit organisations, however they have different levels of capacity and orientation. While ACHS largely provides quality programs for the acute sector and QIC is the main provider in the non medical primary health and community sector, there are nevertheless significant sections of the health industry for which they compete. Therefore there are commercial considerations that would need to be worked through. In addition there are still significant differences in the underlying principles from which each operates.

However, there is a consistent core between the ACHS and QIC quality programs and therefore streamlining and cross-recognition should be possible. There is currently a protocol agreement between ACHS and QIC that attempts to address some of the concerns regarding duplication and competition. It does not, however, appear to be effective in reducing the perception of unnecessary complexity and duplication. A clearer and binding agreement is required. This could, for instance, provide a framework for cross-recognition of prior accreditation in other quality programs such as HACCC and ISO.

Where it is appropriate for more than one quality program to be undertaken by a single agency, the protocol could ensure that duplication was kept to a minimum. The protocol could also ensure services are fully aware of the various quality programs options available, before making a decision as to which is the most appropriate for them.

Both ACHS and QIC programs could use the standards and indicators developed by the other (or others) to reduce fragmentation and better respond to the needs of individual services within the sector. Even if a partnership agreement cannot be reached, ACHS and QIC could jointly develop standards that could then be used in both programs. Apart from the duplication and confusion that can be caused by two or more sets of standards being developed for the same program area, this process is unnecessarily resource-intensive for the quality programs themselves.

Another mechanism which may increase the efficiency of quality program delivery to services undertaking more than one quality program accreditation could be the pooling and multi-skilling of reviewers. The profile of ACHS reviewers is around senior management in the hospital sector. QIC reviewers reflect direct service delivery program areas in the primary

health sector. A small number of reviewers have been trained to review in both programs. The possibility of training more 'dual' reviewers to be used by either or both programs should be explored further. The logistics of this - training, payment, appropriate configurations for review teams and differences in orientation - may be complex but there could be considerable return. Not only could duplication of accreditation processes be reduced, but also the value of the advice and support given to services being reviewed is likely to be enhanced by the broader perspectives developed. Such a process may also reduce the traditional cultural divisions between the sectors.

**Recommendations:**

- 2. That quality program providers establish cooperative arrangements aimed at reducing confusion and duplication in program delivery.**
- 3. That quality program providers develop, strengthen and monitor, as appropriate, protocols around the delivery of quality programs in the sector.**
- 4. That information on protocols that have been developed be made available to service providers.**

Standards

A number of issues were raised about standards, including concerns at the possibility of a proliferation of standards and processes for their implementation placing undue pressure on agencies.

There was also a lively debate about the emphasis that should be placed on quality assurance as contrasted with quality improvement. There is still a divergence of opinion about the extent to which quality processes should focus on mandatory achievement or pre-set essential requirements versus a model that emphasises participation in an ongoing quality improvement program. There was more support, for mandatory compliance with standards in instances where minimum standards had been identified, and in particular where there were issues of care and protection of the vulnerable.

The role of consumers and concerns that standards and accreditation processes is also important. Consumer expectations are central to the development of standards and their involvement is essential. Efforts should be made to ensure consumers understand what an accreditation process aims to achieve and the significance of certification. They must also be informed in order to participate productively in both standards development and review processes where this is indicated.

Whether standards should focus on process or outcomes was also controversial. There needs to be a better connection between accreditation, continuous quality improvement and outcomes. Although there are clinical indicators for the hospital sector, there is no equivalent for the primary health sector. An outcome framework remains to be developed. The Commonwealth should consider funding the development or redevelopment of standards and indicators that better reflect outcomes in the primary health sector, although there are significant conceptual and practical challenges to be overcome.

There is a strong case for the continuance of the QIC model that emphasises the use of a Core Module covering standards likely to be common to most primary health and community services agencies, and specific content modules for particular service types. Where specific content modules for service sectors are developed by State, Territory and Commonwealth jurisdictions, it is desirable that they are complementary to existing standards models and quality improvement systems. QIC has moved to overcome some of these difficulties by introducing a process for ratifying new content modules that are produced for QIC accreditation.

Although some gaps were identified in the current standards, such as those for gender-specific agencies and agencies providing information and advocacy, these could be addressed by the addition of some specific indicators to existing standards systems, rather than the development of new additional sets of standards. Alternatively the need for new standards may be circumvented by identification of current best practice examples appropriate to new areas, which can then be used in conjunction with appropriate existing standards. This could assist with addressing the issue of standards proliferation and move the focus for quality programs and government from standard development to implementation processes and resourcing issues.

**Recommendations:**

- 5. That an appropriate framework to guide further standards development for primary health and community services be developed, taking account of existing frameworks and other relevant proposals, to prevent the proliferation and duplication of standards across the sector.**
- 6. That an appropriate mechanism to review and monitor standards development for primary health and community services, that includes stakeholder interests, be established.**
- 7. That the development of outcome standards for the community health sector be re-examined.**

Implementation of review processes

As discussed above, a number of concerns were raised regarding implementation of quality review processes. Suggestions were made around streamlining the accreditation process, improving the quality of reviewers and ensuring they are appropriate to the service being reviewed, and better integrating the accreditation process into a continuous quality improvement approach. Ongoing support for agencies in quality programs outside the review process was raised as an issue.

Comments were also made that although standards were seen as a measuring mechanism, they appeared not to be reliable. Some thought scores were not meaningful, others thought discrepancies between reviewers and review teams should be addressed.

**Recommendations:**

- 8. That quality program providers ensure that review teams are appropriate to the service to be reviewed.**
- 9. That quality program providers ensure that they provide advice and support to agencies within their programs, both through the formal review process and at other times.**
- 10. That quality program providers have appropriate mechanisms in place to ensure their programs are rigorous, including reviewer training and monitoring of the review process.**

Reporting requirements

Another issue for services is around duplication of reporting requirements. Funders often have different requirements for each of a number of programs being delivered by a service. In addition, it is likely that agencies will have more than one funder.

Governments require services to report regularly against their service agreements and this can be a disproportionate burden for smaller services particularly if funds are limited. There was also some skepticism from a number of those interviewed both within and outside

government, as to the extent to which this data was productively used. Concern was expressed at the lack of integration between government reporting requirements and those of quality program providers.

Consideration should be given to greater integration of reporting against standards into ongoing services agreements. A quality program such as QIC could then monitor and review the service's performance against the service agreement/ standards. However, in many cases this would require significant modification to the program and funding guidelines which determine the form of existing service agreements.

Nevertheless, the greater linkage of quality programs with service agreements has the potential to reduce transaction costs to agencies while at the same time increasing the emphasis on participation in quality programs.

**Recommendation:**

- 11. That the integration of quality standards and review process into service agreements be piloted and evaluated by quality program providers.**

Resourcing issues

With the defunding of the Australian Community Health Association and QIC by the Commonwealth, there is now something of a vacuum in the coordination and resourcing of national initiatives for standards development, monitoring and the promotion of quality improvement for primary health and community services. While the establishment of the Australian Council for Safety and Quality in Health Care is an important step in this respect, the Council is strongly focused on the acute sector. Similarly, the development of an accreditation system for general practitioners, while an important for improving quality in primary care, has little relevance to the range of community and primary health agencies funded through State and Territory governments. It is important that appropriately resourced national coordinating structures and processes are put in place to address this gap for publicly funded primary health and community services.

The majority of those interviewed thought government should make a contribution towards the cost of participating in quality program activities. This is particularly true for the community health sector where funding constraints are extreme, and the size of agencies means that there is little capacity to redirect resources away from direct service provision. Both additional funds to participate in the quality programs and for the infrastructure for their delivery were raised.

**Recommendations:**

- 12. That an integrated approach to quality improvement standards for primary health and community services be developed and the resourcing implications for coordination, monitoring and development be investigated.**
- 13. That appropriate arrangements for funding agencies to be involved in quality programs be investigated.**
- 14. That government give particular consideration to ensuring that smaller agencies and those in rural and remote areas in particular, have a capacity to participate in quality programs.**

Information provision

Access to information is crucial to quality improvement, yet a number of stakeholders commented that information on quality issues was hard to obtain, particularly for rural and remote services. In addition information that was available was often esoteric. Concern was

also expressed at the lack of understanding about accreditation generally and what it means for a service to be accredited.

Current and appropriate information must inform quality programs, reviewers, services, consumers and the community at large. Reviewers and consumers are not able to adequately participate in quality improvement processes unless they are informed about current practice around service delivery, options that may be appropriate and, ideally, mechanisms for achieving alternative approaches. Reviewers commented on the need to get together to update information, reflect on issues and to integrate ideas resulting in a more cohesive approach. The difficulty of getting information on quality issues was also a common theme from key stakeholders.

Although there was some skepticism about how they are identified, an important factor in continuous quality improvement is the identification and use of best practice examples. A number of those interviewed expressed concern at the difficulty of obtaining information on appropriate and current best practice examples. In a sector of exponential change such as the health sector, ensuring examples are current is particularly important. In addition, examples are often drawn from international experience and, while this might be useful, there also needs to be more identification of Australian best practice examples, including those for rural and remote services.

Quality programs should have a major role in information provision. Although both ACHS and QIC support continuous quality improvement and believe they provide ongoing advice and support to their client services, this is not a view supported by many of the services themselves. Currently, many agencies believe there is inadequate contact from their quality program providers between reviews. As stated previously, a focus solely on reviews undermines continuous quality improvement. Quality programs should not only offer advice at the time of review, but ongoing support through a variety of mechanisms including direct contact, information provision and networking opportunities.

The Internet is particularly suitable as a cheap and readily accessible distribution point for information. Key stakeholders, service providers and reviewers all expressed an interest in information provision using technology such as email and internet. Reviewers also raised the issue of delivery of information and training using technology both for themselves and their services.

All of the major quality programs in the sector have web sites. Better links could be established between appropriate sites, and other options such as chat rooms could be particularly useful in providing networking opportunities for rural/remote services.

The technological approach should not preclude quality programs and government exploring other possible mechanisms for information provision, including newsletters (although these could also be distributed over the Internet) and seminars. There are obviously resourcing issues which arise from all the options, particularly those involving face to face contact. Once again, this is particularly the case for rural and remote services. Resources are unlikely to be available at individual service level, or with the existing quality programs currently for additional initiatives. Additional resourcing from government would need to be made available to further develop information provision.

Consideration should also be given to providing greater information on service quality to consumers, although there is some controversy about the type of information that should be made available. Apart from information about certification against quality standards, to the extent that there is valid and reliable information on service outcomes, this should be made available to consumers in an accessible format.

**Recommendation:**

- 15. That information resources on quality improvement and assurance be developed for primary health and community services, including appropriate best practice examples, particularly for those in rural and remote areas. The funding arrangements for this development be investigated by the State and Commonwealth Governments.**

Education and training

Education and training around the importance of continuous quality improvement in the health sector was seen by many of those interviewed as central to improving the quality of health service delivery. A number of the respondents in rural and remote services in particular, considered that quality assurance was not clearly understood by staff members at their organisation, and that this was exacerbated by their remote locations and the dearth of appropriate education for services in rural and remote locations..

**Recommendation:**

- 16. That incentives be provided to academic institutions that provide training on addressing quality issues in service provision for the health and community services sector.**

Leadership

Leadership is crucial to the successful implementation of quality programs. Management must be committed to ensuring that continuous quality improvement is integrated into all aspects of the service's operation. If the impetus for the process comes from further down the organisation, there is a greater danger that it is marginalised from day to day activity. Although the managers interviewed during the consultation were deeply committed to quality improvement, they were not a random sample, and are not necessarily representative of managers generally. Many of those interviewed commented that management is generally ignorant about quality issues, and not interested in driving the process within their organisations. Experience in quality is not seen as an advantage for a career path. In addition it was commented that government is providing the wrong incentives to managers. Quality assurance is currently not an important factor in how a manager's performance is judged.

Quality programs are more likely to be successful if management shows it is committed to the process. Clear cost-benefits of participation in quality processes, although difficult, could assist in encouraging management commitment. In addition, marketing quality programs, at least in part, as 'risk management' strategies may also be useful.

Many of those interviewed also commented unfavorably on the lack of leadership and commitment from government at all levels, to quality improvement for primary health and community services. There is not seen to be enough encouragement from government. This view is reinforced by a perceived lack of resources provided for services to pursue a quality agenda. There is a perception that Government is disproportionately concerned with the hospital side of the health sector, to the detriment of the primary health sector and that the Commonwealth has abrogated responsibility to ensuring quality in community health because it is state funded.

There was general agreement that it would be desirable for quality issues for primary health and community services to be addressed nationally. Government at all levels must show commitment to the delivery of quality services across the sector, including addressing the resourcing issues. There currently appears to be a lack of coordination at a national level for addressing quality improvement in the sector. One possibility is the Australian Council for Quality and Safety in Health Care, however the membership and agenda of the Council

appears to be focussed primarily on the acute sector, and at least currently, on safety issues rather than quality issues. Other possibilities include the Law Reform and Quality Section of the Population Health Division, Department of Health and Aged Care, and the National Public Health Partnership. If government is to take a greater role, it would be desirable to have a coordinated response.

**Recommendations:**

- 17. That responsibility for coordination of quality improvement for the health and community services sector nationally be clarified.**
- 18. That agencies be encouraged by key stakeholders including Local, State and Commonwealth governments to participate in quality program activities and that this be a condition of funding.**
- 19. That Commonwealth, State and Local governments use every opportunity to emphasise their commitment to delivery of quality services in the health and community services sector, including giving consideration to instituting national and state based awards for quality initiatives.**

## Rural and remote services

Issues of particular importance to rural and remote services have been abstracted from the main report and included in a separate section to highlight their importance. Rural/remote services shared the concerns of other services, however for them the difficulty of participation in quality programs appeared particularly pronounced. There was a sense that the issues for rural and remote services were not being sufficiently recognised by either quality program providers or government.

There were particular issues for rural and remote service providers around the appropriateness of standards and review processes, peer review, and resourcing. There were also particular concerns about information provision and education and training.

### Purpose of accreditation

The importance of accreditation in providing recognition and credibility for services in small communities is important particularly for remote communities. For rural and remote service quality programs are also an important tool for change management, and for placing a greater emphasis on quality in service delivery. Responses to the benefits and costs of the review process varied across states. Those from NSW and Queensland mentioned change management as the major benefit, while the others generally emphasised the continuous improvement or service delivery aspect. This may well reflect the different approaches taken to encouraging services to undertake quality reviews in the different states. Rural and remote services in particular had issues around isolation and high staff turnover. Review processes can contribute to bonding between staff.

### Peer review

Peer review was of particular importance to rural and remote services. Although strongly supportive of the concept of peer review, rural and remote service providers had particular difficulties regarding training of staff as reviewers, and meeting the cost of their time release to undertake reviews.

However, costs of staff participation in reviews may be ameliorated by the experience reviewers brought back to their agencies. Reviewing should therefore be seen as a professional development activity. In smaller services, however, reviewing places a heavy burden on resources.

## Appropriateness of quality programs

The cost of quality programs may lessen the appropriateness of the program selected. In an integrated agency in particular, a single program may be chosen when two parallel processes might be more appropriate. Alternatively just the least costly program may be selected to comply with requirements, rather than the program most appropriate to the service. This is particularly problematic for integrated or multi-service providers.

Primary health and community services which had been integrated with hospital services often risk losing the ability to choose an appropriate review process. In addition, the make-up of review teams themselves was sometimes inappropriate to the service being reviewed when integration has occurred. A common example of this was reviewers with only tertiary hospital experience being used to review small rural facilities.

## Resourcing issues

For rural and remote services costs are a barrier to quality assurance. This includes not only the costs around provision of reviewers but also the fee for participation in the program, and the increased costs of reviews in rural and remote areas, particularly when reviewers are bought in from other states. The need to provide accommodation in a rural or remote location can significantly add to the cost of accreditation as can the cost of on-site education.

## Information provision

Access to information is crucial to quality improvement, however information on quality issues can be difficult to obtain, particularly for rural and remote services. In addition available information is often hard to understand and translate into a rural context. There is also a lack of understanding about accreditation generally and what it means for a service to be accredited. As with education and training, technology could be better used to provide information and education and training to rural and remote services.

## Education and training

Education and training around the importance of continuous quality improvement in the health sector is central to improving the quality of health service delivery. Quality assurance is not clearly understood by staff members in many rural and remote organisations, and that this was exacerbated by their remote locations and the dearth of appropriate education for services in rural and remote locations. The particularly high turnover of staff in rural and remote areas adds to the importance of training for rural and remote service staff.

## Standards

The need for appropriate and flexible standards and implementation processes is particularly important. There was a perception by many of those consulted that the standards used for rural and remote services have been set for or by, major teaching hospitals at a level that makes it impossible for rural services to attain.

There are significant consequences if the standards are inappropriate or implemented inflexibly. The cost implications if services are required to meet inappropriate standards may be significant for rural and remote agencies. The development and implementation process for the standards is therefore particularly crucial. However, the development of standards and the flexibility around their implementation, should not reduce standards in rural areas or give a perception of a lesser service

Consultation is particularly important in rural and remote areas to ensure the standards and the process for their implementation is appropriate. For clinical standards in particular, this means consultation with GPs.

# Summary of Recommendations

The following recommendations arise from the literature review, analysis of the data-base of agency performance against standards and the national consultation.

1. **That regular reports could be provided by accreditation agencies both to assist with monitoring the quality of services in the sector, and in order to contribute to appropriate policy development. The Commonwealth and State governments could have a role in progressing this issue.**

## Cooperation between quality programs

2. **That quality program providers establish cooperative arrangements aimed at reducing confusion and duplication in program delivery.**
3. **That quality program providers develop, strengthen and monitor, as appropriate, protocols around the delivery of quality programs in the sector.**
4. **That information on protocols that have been developed be made available to service providers.**

## Standards

5. **That an appropriate framework to guide further standards development for primary health and community services be developed, taking account of existing frameworks and other relevant proposals, to prevent the proliferation and duplication of standards across the sector.**
6. **That an appropriate mechanism to review and monitor standards development for primary health and community services, that includes stakeholder interests, be established.**
7. **That the development of outcome standards for the community health sector be re-examined.**

## Implementation of review processes

8. **That quality program providers ensure that review teams are appropriate to the service to be reviewed.**
9. **That quality program providers ensure that they provide advice and support to agencies within their programs, both through the formal review process and at other times.**
10. **That quality program providers have appropriate mechanisms in place to ensure their programs are rigorous, including reviewer training and monitoring of the review process.**

## Reporting requirements

11. **That the integration of quality standards and review process into service agreements be piloted and evaluated by quality program providers.**

## Resourcing

12. That an integrated approach to quality improvement standards for primary health and community services be developed and the resourcing implications for coordination, monitoring and development be investigated.
13. That appropriate arrangements for funding agencies to be involved in quality programs be investigated.
14. That government give particular consideration to ensuring that smaller agencies and those in rural and remote areas in particular, have a capacity to participate in quality programs.

## Information provision

15. That information resources on quality improvement and assurance be developed for primary health and community services, including appropriate best practice examples, particularly for those in rural and remote areas. The funding arrangements for this development be investigated by the State and Commonwealth Governments.

## Education and training

16. That incentives be provided to academic institutions that provide training on addressing quality issues in service provision for the health and community services sector.

## Leadership

17. That responsibility for coordination of quality improvement for the health and community services sector nationally be clarified.
18. That agencies be encouraged by key stakeholders including Local, State and Commonwealth governments to participate in quality program activities and that this be a condition of funding.
19. That Commonwealth, State and Local governments use every opportunity to emphasise their commitment to delivery of quality services in the health and community services sector, including giving consideration to instituting national and state based awards for quality initiatives.

# Methodology

## Project management

The project was conducted by the Australian Institute for Primary Care and managed through the QIC Secretariat. A project Steering Committee comprising three Board members and the Executive Officer was established together with a project reference group. A list of Reference Group members is attached (Appendix 1).

## Key task 1: Literature and document review

The published literature and available documents on quality systems for primary care, community services and health promotion and local public health services were reviewed to compare and analyse the characteristics of quality improvement approaches. The review provided a comprehensive conceptual framework for analysing approaches to quality improvement, assurance and accreditation in these areas.

Quality framework documents, which are relevant and recommended for these services, were obtained and reviewed including processes for their development and maintenance, and the systems for implementing them.

Standard electronic literature search techniques were supplemented by direct contact to obtain relevant documents. The literature review was prepared as a separate document, however a summary of the review is a chapter of the final report.

## Key task 2: Stakeholder consultation

A consultation was undertaken with key stakeholders including funders, consumers, providers and reviewers to investigate the factors that influence the successful development and implementation of quality frameworks across different program areas and agency types. Professional organisations and academics with an interest in standards development were also consulted.

### Identification of stakeholders

Reviewers and service providers were identified by the QIC regional managers and selected to provide a cross section of experience and jurisdiction.

The Key Stakeholders group was selected to ensure representation of consumer and service provider interests through peak bodies, a cross section of program areas through large service providers and professional associations, and funder interests through key personnel in State and Commonwealth bureaucracies. Other individuals or organisations identified as having particular expertise in quality programs were also categorised as Key Stakeholders. Suggestions were sought from the Reference Group, Steering Committee, the National Public Health Partnership, Commonwealth and QIC Regional Managers, for individuals or organisations who would be appropriate to approach to request their participation in the consultation.

### Consultation Process

Reviewers and service providers were consulted through focus groups where it could be reasonably expected that they would attend, such as in metropolitan areas. Telephone interviews were used to supplement this where key people could not attend. Telephone interviews were also used for those from rural/ remote areas. Focus groups were arranged in cooperation with QIC regional organisations. Separate focus groups were undertaken for reviewers and service providers in Victoria, NSW and Queensland. A focus group of

reviewers was also undertaken in Tasmania, however service providers in this instance were consulted through individual interviews.

Key Stakeholders were interviewed face to face where possible. Telephone interviews were also undertaken of those key stakeholders who could not otherwise be interviewed due to time or location issues. The consultation process included:

- the initial call requesting a discussion in regard to quality reviews;
- the forwarding the a brief project background and focus of the interview;
- the interview on the date specified by the respondent;
- documentation of the interview;
- collation of the information;
- identification of patterns and trends in the gathered information; and
- reporting.

There was some variation in the questions put to focus group reviewer and provider participants and those key stakeholders interviewed individually. The proforma for reviewers and service provider focus groups is attached (Appendix 2), together with the semi-structured interview proforma designed for Key Stakeholders (Appendix 3).

### Key task 3: Analysis of agency performance on QIC standards

The QIC national database was used to examine agency performance on QIC core standards and modules. Comparative performance on standards across agency types, jurisdictions and program areas was reported.

Cross-tabulations of frequency counts of standards scores were undertaken. The data was initially sorted by module then grouped by either agency type, program area, jurisdiction or standard. Frequency counts of scores in each group were calculated and presented as tables of percentages under the possible outcomes: *exceeded, met, met in part, not met or not applicable*. In addition, tables were developed for agency performance against individual standards from the Core and Primary Health Care modules nationally.

### Key task 4: Consultation with reference panel

A reference group comprising specialists on quality improvement and assurance was established. The reference group was consulted at appropriate milestones, on completion of the literature review, and completion of the stakeholder consultation phase. Membership of the reference group is outlined in Appendix 1. The reference group was consulted through email.

### Key task 5: Report writing

A report outlining the methodology, findings and conclusions from the project was prepared.

## Summary of Literature Review

This section summarises the review of the literature which was conducted. A full report of the review has been published as a separate report.

### Standards, Accreditation and Continuous Quality Improvement

In the 1990s the quality focus in health care services turned to continuous quality improvement (CQI), changing the way we look at standards and the accreditation process. The suitability of using standards for promoting quality improvement was questioned as the notion of standards traditionally implied clear-cut criteria and fixed points in the definition of quality, whereas CQI necessitated a continual process of self-examination without a fixed destination.

The tension between these two concepts was resolved by standards agencies developing more flexible and less prescriptive standards; by encouraging health organisations to follow their own quality journey to improve quality and performance; to meet standards; and to review the quality of care they provided.

The review of the literature focused on service delivery standards as applied to organisations through systematic external review procedures (accreditation).

There are a number of factors influencing the type of standards in use in organisations. Two of the most important are that sets of standards may differ in terms of their mix of structure, process and outcome standards as described by Donabedian (1982), or in terms of their position on the continuum of minimal to optimal standards.

The traditional focus in health care has been directed more towards structure, and process standards in particular as outcomes are, in many health care settings, difficult to define and evaluate. There has however been a strong recent trend towards outcome measurement in the accreditation process.

Accountability to consumers through accreditation has taken on greater public significance in recent years. Meeting the current public and governmental demand for improved accountability through accreditation requires increased resources and places additional financial burden on health care organisations, especially if a variety of quality programs must be adhered to.

Accreditation is well established in some countries, including the USA, Australia, N.Z., Canada, Spain and the UK. The American model of health care accreditation has directly shaped the systems in Canada and Australia and indirectly influenced developments in Britain, although in the US it plays a more regulatory role.

### Standards Agencies and Standards Products

The main agencies that develop commercial standards for health care organisations in Australia are the Australian Council on Health Care Standards (ACHS), predominantly used in institutional settings, and the Quality Improvement Council (QIC) standards designed for community and primary care settings. The Home and Community Care (HACC) program has also developed their own standards which apply to HACC funded agencies only. Similarly, the Royal Australian College of General Practitioners (RACGP) has developed commercially available standards for general practices. The ISO (International Standards Organisation) quality standards, represented in Australia by Standards Australia, and the Australian Quality Council's (AQC) Australian Business Excellence Framework (ABEF) can both potentially be applied across all industries, although they are not currently widely used in the health care sector.

## **ACHS**

The ACHS accreditation program combines the Evaluation and Quality Improvement Program (EQuIP), consisting of a standards and review process, with the Performance Outcome Service (POS) program of clinical indicators. The clinical indicators were introduced in 1993 and address both management processes and outcomes of clinical care, giving the ACHS's accreditation program a strong outcome orientation.

Organisations using ACHS accreditation undergo self-assessment followed by an organisation-wide survey. The focus of accreditation is as much on the results of the current review as on how the organisation has used reviewer's feedback to make changes within the organisation and focus on CQI.

Results reported from the EQuIP and POS programs have been positive although the validity of using clinical indicator data has been questioned, especially when used to make comparisons of performance across organisations.

## **QIC**

The QIC accreditation program (formerly CHASP) promotes a culture of organisational change, growth and development. It provides a flexible approach which can be applied across a variety of health and community organisations. QIC standards are available in modular form, including a generic core set of standards and complementary service delivery modules for specific service types, such as primary health care services, homes based care services or alcohol, tobacco and drug services.

QIC accreditation begins with an internal assessment followed by a review process carried out by a team of external peer reviewers and an internal contact. Positive outcomes have resulted from the implementation of review recommendations.

## **HACC**

HACC standards are designed specifically for HACC funded services. These services provide assistance to people who are at risk of premature or inappropriate long-term care, and their carers.

The standards were first introduced nationally in 1995, making it compulsory in all states and territories to include them in all service agreements. A Standards Instrument has been developed and piloted, showing good levels of reliability and validity.

At this point in time the accreditation system is not in use and the infrastructure and funding needed to support accreditation has not yet been determined. When the process is established service appraisals using the instrument will be linked to agency funding.

Two methods of assessment have been planned: Joint Assessment and Self-Assessment with Verification. A consumer assessment component is also being refined for use as part of the survey process.

## **RACGP**

The RACGP spent four years developing a set of standards which were released in 1996, with a new edition due in mid 2000. Standards were introduced from early 1997 to encourage all general practitioners to voluntarily improve their practices. They were designed as a peer assessment process to be undertaken during a practice visit.

Operation of the system has recently begun, with a number of accreditation bodies offering accreditation against RACGP standards. The first agency authorised to do so was Australian General Practice Accreditation Ltd (AGPAL), followed by Quality Assurance Services (QAS).

Currently some 60% of practices in Australia have registered with either AGPAL or QAS for accreditation.

## **ISO**

ISO is a world federation of national standards bodies represented in Australia by Standards Australia. ISO aims to promote the development of world standardisation across different industries and achieve customer satisfaction through consistency of product.

Standards Australia develops generic standards in cooperation with Australian government and industry, utilising the international ISO standards. Healthcare organisations can be accredited using ISO standards by a number of agencies. However these agencies need to be certified by the Joint Accreditation System of Australia and New Zealand (JAS-ANZ).

ISO standards use the language of manufacturing and engineering industries for which they were originally developed. This creates a barrier for their use in health care. It is argued that their focus on concrete products and assessment for uniformity and non-variability, make them most applicable to the more tangible aspects of health care, such as occupational health and safety, and less appropriate for general health care services.

Standards Australia has published an explanatory guide for using ISO 9001/2/3 in health services. ISO 9001:2000 has also recently been released, ultimately to replace ISO 9001/2/3 and to introduce a more customer focused approach and continuous quality improvement (CQI) elements of accreditation. ISO's main barrier to use, particularly in the health care sector, remains the technical language of the standards.

## **AQC**

The AQC provides recognition to organisations that can demonstrate best practice and organisational excellence. The AQC's mission is to accelerate organisational improvement through the adoption of the management principles and practices that are reflected in the Australian Business Excellence Framework (ABEF). ABEF adopts a generic model which can be used across all organisations.

The ABEF is not a process of accreditation but a vehicle for recognition. Self-assessment is a prerequisite for ABEF recognition and a specific health care validation process is currently being developed. The ABEF does not take the place of an accreditation system.

## **Other Standards products**

Other accreditation systems are in place and other standards products are used in the health care sector. One which operates on a large scale is the Aged Care and Accreditation Agency's 'Standards and Guidelines for Residential Aged Care Services.' A fully functioning accreditation process is currently in use and by the end of 2000 it will be compulsory for all residential aged care organisations to be accredited.

There are also national standards with accreditation programs planned for disability (the Disability Service Standards) and mental health (the National Standards for Mental Health Services) services.

## Proliferation and diversity of standards

There is no coordinated approach by governments or standards agencies to prevent duplication of standards across organisations and service delivery areas even though some services, such as multi-purpose organisations, are faced with meeting a range of different standards and accreditation requirements. Improved linkages and coordination between the current accreditation and CQI approaches are needed to minimise duplication and confusion for health service organisations about expected standards of care.

## Development and use of standards

An international conference in Treviso, Italy, in 1994 identified principles for successful standards development. These are outlined in the following review in addition to factors identified from the literature as being important to standards development and use.

In general, standards need to be specific yet flexible to individual institutions, to relate to quality of care and to the environment of care and to focus on continuous quality improvement (CQI). They need to be built on consensus, have clear objectives, be achievable and be measurable. It is considered important that standards be outcome oriented, be locally developed in consultation with consumers and be applicable to both small rural, as well as large metropolitan organisations.

Three of these factors, outcome orientation, focus on CQI and consumer involvement, have been particularly topical recently and the subject of much discussion.

### **Outcome orientation**

Outcome measurement has become an increasingly important focus of CQI and accreditation in recent years, with all standards organisations attempting in some way to address this.

One of the ways services have tried to be outcome oriented has been through the measurement of performance through clinical indicators, as the ACHS has done. These indicators potentially cover all areas of hospital practice and are able to use a database of normative statistics gathered through hospital surveys. Reliability is difficult to achieve using indicator data however due to data collection methods and observer bias. The validity of using POS data as a comparative measure between hospitals has also been questioned in a number of government reports. It is concluded that the information presently available in major administrative databases is of limited clinical value and current indicators are not accurate guides to quality of care delivered by hospitals. Monitoring of indicators is nevertheless considered a useful component of CQI programs.

It is recognised that there is future in the use of clinical indicators in health care although there is a long way to go before they become valid and reliable measures to make comparisons of hospital quality.

It has also been suggested that clinical indicators be used in other areas of health care such as community care. While this is a possibility, an adequate framework (including reliable means of data collection) has not been developed and significant limitations and difficulties have been identified. Currently, alternative outcome measures are being used in areas of health care other than acute care.

Whether clinical indicators are used or not, the challenge facing standards agencies is to improve outcome measurement and to provide quality outcomes in health care.

## Consultation with consumers

The focus of quality in health care is increasingly shifting towards the assessment of quality in terms of the experience of the care recipients. In order for consumers to be equal partners in the treatment and care they receive, they need to participate in both the setting of standards as well as the evaluation of care against those standards in term of their own experience. The development of meaningful carer and consumer participation is an essential element of best practice. Few accreditation systems currently provide opportunities for consumers to be involved in the review process and none of the standards agencies reviewed make direct contact with consumers a mandatory requirement. QIC has however recently made the involvement of consumers in the ongoing operation of the agency one of the essential requirements for QIC accreditation.

## Focus on CQI

The accreditation process is seen by many as a time of frantic activity in the lead up to the survey followed by inactivity the rest of the time. It is generally accepted however, that improvements should be continuous and there should be the same level of compliance with standards at any given time. Standards agencies such as QIC and ACHS have incorporated CQI into their review processes by requiring that quality activities be implemented in organisations between survey periods.

Issues to consider for successful achievement of accreditation and CQI in organisations

Some consistent factors have emerged through empirical studies, that make health care agencies more likely to succeed in the accreditation process. The most common and important of these is the participation and leadership of senior management in quality activities. It has also been recognised that involvement in the accreditation process needs to be voluntary and that confidentiality of sensitive information is assured.

## Conclusion and recommendations

Although there are a number of quality programs available in the health sector, the major players in accrediting health care organisations remain the QIC for community settings, and the ACHS for institutional settings. HACC (a program that has not yet developed the infrastructure to deliver their planned accreditation program) has also developed standards specifically for Home and Community Care, and the RACGP (for which an accreditation program has begun) for GP care. ISO develops the ISO 9000 standards that can be used across all industries including health care, and AQC has an ABEF framework that presents quality awards to businesses across all industries.

The Standards Agencies strive for CQI and to have optimal standards. However the agencies that have developed standards in consultation with health professionals such as the QIC and the ACHS, are more likely to have optimal standards as they are developed within the health care sector and can address issues specific to health that the generic standards cannot. They have an advantage over generic standards products such as ISO in that they are specifically designed for the health care sector and are "owned" by it. To maintain and strengthen this advantage it is important to have key stakeholder interests involved in the continuing development, review and assessment of standards. For example, in creating new drug and alcohol service standards it would be important to involve professional and consumer groups from the drug and alcohol field.

There is also increasing pressure for standards to be outcome oriented. Outcome focused standards have increasing importance at many levels of government in Australia with the widespread introduction of market-oriented policies causing an increasing focus on the measurement of health. Primary health care has traditionally had a strong focus on the

structure and process principles of quality, however it is now important to have a clearer focus on outcomes.

All the agencies attempt to address this issue in some way, some with more success than others. The ACHS has developed clinical performance indicators, through which the outcome of clinical care can be judged, although there has been concerns over the validity of the data. The QIC and other agencies have not introduced performance indicators for many reasons, including the different sort of activities involved in community based care compared to institutional care. However, the databases which are increasingly being kept and which document treatments and outcomes for many areas in health care could provide data for such indicators. The push for performance indicators in primary and community health care may become stronger in the near future. Whether performance indicators are used or not, the challenge facing standards agencies working in the health care area today is to improve measurement of outcomes and provide better quality outcomes to communities and individuals.

Another important consideration for standards agencies is to actively promote and ensure consumer involvement, especially in the evaluation of health services. HACC and the QIC seem to be strongest in this area, and HACC is refining a consumer assessment measure to be included in the review procedure. In general, agencies could improve by requiring the organisations they accredit to involve consumers and consumer groups more in their service and in the CQI process and also by having more contact with consumers during the review process.

A very important issue affecting CQI in health care organisations is the duplication of standards. There have been strong calls for improved linkages and coordination between the range of current accreditation approaches. Although there is a proliferation of standards in different area of health care, in many cases (e.g., HACC and the National Mental Health Standards) there is no systematic mechanism for implementation and no accreditation system, making it at times unclear which standards services need to comply with and if they do comply with them. Recent developments in Australian public health care have included the development of multipurpose services and amalgamations of community health and hospital services, often further complicating matters by resulting in overlapping demands for the implementation of a variety of standards within a single agency.

Duplication (and therefore a health care organisation's time and resources spent on CQI) needs to be reduced. It should be possible to devise some mutually advantageous arrangements whereby there is some form of reciprocal recognition between agencies, such as the protocol agreement between the QIC and the ACHS. At a minimum, it is important that quality agencies work together to avoid overlapping requirements whereby one service may be asked to duplicate processes already undertaken.

Apart from the traditional stakeholder base of agencies, standards agencies (such as the ACHS and QIC) are now moving into new service sectors, which will mean redefining their stakeholders. To gain a bigger share in an increasingly competitive market, standards agencies will need to develop broader bases and define the stakeholders needed to expand into new service areas.

## Analysis of Agency Performance on QIC Standards

The Quality Improvement Council Limited (QIC) is a national advocacy organisation that aims to promote, assist and develop health and community services across Australia. It is responsible for the coordination of the Australian Health and Community Services Standards and other quality improvement services.

The QIC Program (formerly known as CHASP) has been in operation for over a decade. It has a well-established set of standards and review processes. Over 300 health and community service agencies currently participate in the QIC Program. The QIC Program is delivered nationally by four Regional Organisations in Queensland, New South Wales, Victoria and Tasmania. Some regional organisations review agencies in more than one state. Agencies in all states and territories are accredited through the QIC programs. Over 800 QIC reviewers conduct the quality assurance and improvement process.

The current QIC Program has however only been in operation since 1998 and its data-base is still being developed. In addition, a number of regional providers of the Program extended the 'phase in' of the new Program and continued to deliver CHASP to services for some time after QIC was developed. As the CHASP standards differ from the QIC standards, the scores are not comparable across the two programs. Only the QIC data from accreditation reviews has been used in this data analysis, therefore reducing the number of agencies involved. In addition, some modules are newly developed, and others have not had significant use. Analysis has only been undertaken where there is significant data available. The following reports on data accreditation reviews from 81 agencies in total using four modules. Some discrepancies in figures occur where not all standard scores have been provided.

In the QIC Program, agency performance on standards are reported from one to five; one is *Exceeded*, two *Met*, three *Met in Part*, four *Not Met* and five *Not Applicable*. The *Not Applicable* designation allows the variation between agencies to ensure that they are not forced to comply with inappropriate standards.

In the QIC process, indicators are examined to assist in establishing how a standard is scored, however the indicators are not aggregated to form an overall score. In general, review teams make a judgement taking into consideration all the information that is available to them, including verification of indicators, before scoring an agency's performance against the standards. Both qualitative and quantitative processes are therefore involved in the process, and there may be some variation between regional providers as to how the balance between the two is reached.

The QIC Program is delivered through a modular approach. It is a requirement of the Program that all agencies use the Core Module, however other service specific modules can then also be used. For example a community health service is likely to use the Core Module and the Primary Health Care Module. Another service might use the Core Module with the Integrated Health Services Module if this was more appropriate.

The following is an analysis of agency performance in QIC accreditation reviews by jurisdiction, agency type and program area. The tables are cross-tabulations of frequency counts of scores on standards. The data was initially sorted by module then grouped by either agency type, program area, jurisdiction or standard. Frequency counts of scores in each group were calculated and displayed in the following tables as percentages under the possible outcomes: *Exceeded*, *Met*, *Met in part*, *Not met* or *Not applicable*. In addition, Tables 13 and 14 provide information on agency performance against individual standards from the Core and Primary Health Care Modules nationally.

## Agency type

The traditional client base for the QIC Program is with non-acute services, in particular community health services. More recently however QIC has reviewed a number of agencies with in-patient or residential care (beds) as part of their service delivery. This is particularly the case in rural or remote locations, or where a range of agencies have amalgamated.

The data was sorted according to whether the service being reviewed offered in-patient or residential care (beds) as part of their service delivery.

The following tables show agency performance for modules nationally across agency types.

**Table 1: Core Module**

Agency Type	Score %					Number of Agencies
	Exceeded	Met	Met in Part	Not Met	Not Applicable	
<b>No Beds</b>	1.9	74.0	22.4	1.5	0.2	72
<b>Beds</b>	2.5	68.2	28.9	0.5		9
<b>Total</b>	<b>1.9</b>	<b>73.4</b>	<b>23.1</b>	<b>1.4</b>	<b>0.2</b>	<b>81</b>

Eighty-one agencies are represented in Table 1, 72 without beds and nine with beds.

On average, 74.0% of the standards for the Core Module were *Met* in agencies without beds, with a further 1.9% of standards *Exceeded*. Over 22% of standards were *Met in part*, and 1.5% of standards were *Not met*. Only .2% of Core Module standards were designated *Not applicable*.

Of those services with beds, 68.2% of the standards for the Core Module were *Met*, with a further 2.5% of standards *Exceeded*. Over 28.9% of standards were *Met in part*, and .5% of standards were *Not met*. No Core Module standards were designated *Not applicable* in agencies with beds.

**Table 2: Primary Health Care Module**

Agency Type	Score %					Number of Agencies
	Exceeded	Met	Met in Part	Not Met	Not Applicable	
<b>No Beds</b>	0.8	70.4	23.5	2.0	3.2	57
<b>Beds</b>		88.7	7.5	1.9	1.9	3
<b>Total</b>	<b>0.8</b>	<b>71.4</b>	<b>22.7</b>	<b>2.0</b>	<b>3.2</b>	<b>60</b>

Sixty agencies are represented in Table 2, 57 without beds and three with beds.

On average, 70.4% of the standards for the Primary Health Care Module were *Met* in agencies without beds, with a further .8% of standards *Exceeded*. Over 23% of standards were *Met in part*, and 2.0% of standards were *Not met*. Three point two percent of Primary Health Care Module standards were designated *Not applicable*.

Of those services with beds, 88.7% of the standards for the Primary Health Care Module were *Met*, with no standards *Exceeded*. Over 7.5% of standards were *Met in part*, and 1.9% of standards were *Not met*. Approximately two percent of Primary Health Care Module standards were designated *Not applicable* in agencies with beds.

**Table 3: Home Based Care Module**

Agency Type	Score %					Number of Agencies
	Exceeded	Met	Met in Part	Not Met	Not Applicable	
<b>No Beds</b>	6.6	75.7	5.1	1.5	11.0	8
<b>Beds</b>	5.9	88.2			5.9	1
<b>Total</b>	<b>6.5</b>	<b>77.1</b>	<b>4.6</b>	<b>1.3</b>	<b>10.5</b>	<b>9</b>

Only nine agencies are represented in Table 3, eight without beds and one with beds.

On average, 75.7% of the standards for the Home Based Care Module were *Met* in agencies without beds, with a further 6.6% of standards *Exceeded*. Over 5% of standards were *Met in part*, and 1.5% of standards were *Not met*. Eleven percent of Home Based Care Module standards were designated *Not applicable*.

Of the one service with beds, 88.2% of the standards for the Home Based Care Module were *Met*, with 5.9% of standards *Exceeded*. No standards were *Met in part* or *Not met*, however 5.9% of Home Based Care Module standards were designated *Not applicable* in this agency with beds.

**Table 4: Integrated Health Services Module**

Agency Type	Score %					Number of Agencies
	Exceeded	Met	Met in Part	Not Met	Not Applicable	
<b>No Beds</b>		57.1	23.8		19.0	1
<b>Beds</b>		55.7	41.0	1.6	1.6	3
<b>Total</b>		<b>56.1</b>	<b>36.6</b>	<b>1.2</b>	<b>6.1</b>	<b>4</b>

Only four agencies are represented in Table 4, one without beds and three with beds. Consequently the findings should be treated cautiously.

On average, 57.1% of the standards for the Integrated Health Services Module were *Met* in the agency without beds, with no standards *Exceeded*. Twenty-three point eight percent of standards were *Met in part*, and no standards were *Not met*. Nineteen percent of Integrated Health Services Module standards were designated *Not applicable*.

Of the three services with beds, 55.7% of standards for the Integrated Health Services Module were *Met*, with no standards *Exceeded*. Forty-one percent of standards were *Met in part* and 1.6% of standards *Not met*. One point six percent of Integrated Health Services Module standards were designated *Not applicable* in agencies with beds.

### Program area

In the majority of cases, the services reviewed under the QIC Program were Generalist/Community Health Services offering a range of programs. However in some cases only certain program areas within the service are reviewed. In addition, stand-alone agencies that are program specific have also joined the QIC Program.

The data was also sorted by module and program area.

The following tables show agency performance for modules nationally across program areas. Although included in the table, in a number of instances only one agency is represented in the program categories making conclusions regarding these program areas unreliable.

**Table 5: Core Module**

Program Area	Score %					Number of Agencies
	Exceeded	Met	Met in Part	Not Met	Not Applicable	
Aboriginal health		30.4	69.6			1
Aged Care		23.5	70.6	5.9		1
Child & Family		89.1	10.9			2
Child Development		91.3	8.7			1
Diabetes		47.8	47.8	4.3		1
Division of GP's	4.3	95.7				1
Drug & Alcohol		100				1
Family Planning		26.1	69.6	4.3		1
Generalist/Community	1.9	73.9	22.6	1.5	0.1	33
HIV/AIDS		87.0	8.7		4.3	1
Home Nursing	2.9	88.4	8.7			3
Multipurpose Service		30.4	65.2	4.3		2
Other		74.7	19.8	5.5		4
Unknown	2.4	75.5	21.1	0.8	0.2	27
Women's Health		71.4	28.6			1
Youth Health	17.4	78.3	4.3			1
<b>Total</b>	<b>1.9</b>	<b>73.4</b>	<b>23.1</b>	<b>1.4</b>	<b>0.2</b>	<b>81</b>

Table 5 indicates that of those program areas with more than one agency represented in the data, Home Nursing (91.3%), Child and Family Services (89.1%) and Generalist/Community Health Services (75.8%) had the most standards for the Core Module *Met* or *Exceeded*. Multipurpose services had the lowest number of standards *Met* (30.4%) although only two services are represented in the data.

**Table 6: Primary Health Care Module**

Program Area	Score %					Number of Agencies
	Exceeded	Met	Met in Part	Not Met	Not Applicable	
<b>Child &amp; Family</b>		88.9	5.6		5.6	2
<b>Child Development</b>		100.0				1
<b>Diabetes</b>		72.2	16.7	5.6	5.6	1
<b>Division of GP's</b>	6.3	93.8				1
<b>Family Planning</b>		61.1	33.3	5.6		1
<b>Generalist/Community</b>	0.4	70.2	25.5	2.6	1.3	31
<b>Other</b>		58.3	16.7	8.3	16.7	2
<b>Unknown</b>	0.9	70.1	23.7	0.6	4.7	19
<b>Women's Health</b>		68.7	31.3			1
<b>Youth Health</b>	11.1	83.3			5.6	1
<b>Total</b>	<b>0.8</b>	<b>71.4</b>	<b>22.7</b>	<b>2.0</b>	<b>3.2</b>	<b>60</b>

Only two program areas had more than one agency represented in the data for the Primary Health Care Module. (Table 6 above) Child and Family Services agencies *Met* 88.9% and *Met in part* 5.6% of the standards for the module. Generalist/Community Health Services *Met* 70.2% of standards, with a further .4% *Exceeded* and 25.5% *Met in part*.

**Table 7: Home Based Care Module**

Program Area	Score %					Number of Agencies
	Exceeded	Met	Met in Part	Not Met	Not Applicable	
<b>Generalist/Community</b>	17.6	47.1	11.8		23.5	1
<b>HIV/AIDS</b>		64.7			35.3	1
<b>Home Nursing</b>		90.2	7.8	2.0		3
<b>Unknown</b>	10.3	77.9	1.5	1.5	8.8	4
<b>Total</b>	<b>6.5</b>	<b>77.1</b>	<b>4.6</b>	<b>1.3</b>	<b>10.5</b>	<b>9</b>

Table 7 indicates that although nine agencies are represented in the data relating to the Home Based Care Module overall, only the Home Nursing program area had more than one agency represented.

Ninety point two percent of the Home Based Care standards were *Met* by the Home Nursing program area, with a further 7.8% *Met in part*. Over 77% of standards were *Met* overall, with a further 6.5% *Exceeded*.

Although it was not the case for Home Nursing, both other agencies had high rates of standards designated *Not applicable*; HIV/AIDS 35.3% and Community Health 23.5%.

**Table 8: Integrated Health Services Module**

Program Area	Score %					Number of Agencies
	Exceeded	Met	Met in Part	Not Met	Not Applicable	
<b>Multipurpose Service</b>		5.0	90.0	5.0		1
<b>Other</b>		66.7	28.6		4.8	1
<b>Unknown</b>		75.6	14.6		9.8	2
<b>Total</b>	<b>0.0</b>	<b>56.1</b>	<b>36.6</b>	<b>1.2</b>	<b>6.1</b>	<b>4</b>

Only four agencies are represented in Table 8 relating to the Integrated Health Services Module overall, with no program area having more than one agency represented.

There were no instances of standards being *Exceeded*, however 56.1% of standards were *Met* overall and a further 36.6% *Met in part*.

## Jurisdiction

The following tables show agency performance for modules across states and territories.

**Table 9: Core Module**

State	Score %					Number of Agencies represented
	Exceeded	Met	Met in Part	Not Met	Not Applicable	
<b>ACT</b>		47.8	47.8	4.3		1
<b>NSW</b>	1.4	62.8	33.2		0.6	22
<b>QLD</b>	0.8	87.9	11.4			23
<b>SA</b>	3.3	93.5	3.3			4
<b>TAS</b>	6.5	72.8	18.5	2.2		8
<b>VIC</b>	2.0	65.9	29.9	2.2		22
<b>WA</b>		87.0	13.0			1
<b>Total</b>	<b>1.9</b>	<b>73.4</b>	<b>23.1</b>	<b>1.4</b>	<b>0.2</b>	<b>81</b>

Table 9 indicates that 73.4% of Core Module standards were *Met* nationally, with a further 1.9% *Exceeded*. Twenty-three percent of standards were *Met in part*, and 1.4% of standards were *Not met*.

South Australia had the highest number of standards *Met* or *Exceeded*, followed by Queensland and Western Australia. It should however be noted that only one agency is represented in the Western Australia data.

**Table 10: Primary Health Care Module**

State	Score %					Number of Agencies
	Exceeded	Met	Met in Part	Not Met	Not Applicable	
<b>ACT</b>		72.2	16.7	5.6	5.6	1
<b>NSW</b>	1.8	66.4	22.6	2.5	6.7	16
<b>QLD</b>	0.4	87.3	10.2		2.0	14
<b>SA</b>	1.4	83.3	11.1	1.4	2.8	4
<b>TAS</b>		58.3	34.7	1.4	5.6	4
<b>VIC</b>	0.3	63.1	33.0	3.3	0.3	20
<b>WA</b>		88.9	5.6		5.6	1
<b>Total</b>	<b>0.8</b>	<b>71.4</b>	<b>22.7</b>	<b>2.0</b>	<b>3.2</b>	<b>60</b>

Table 10 indicates that over 71% of the Primary Health Care Standards Module standards were *Met* nationally, with a further 0.8% *Exceeded*. Almost twenty-three percent of standards were *Met in part*, and two percent of standards were *Not met*. Over three percent of Primary Health Care Module standards were designated *Not applicable*.

Western Australia and Queensland had the highest number of standards *Met* or *Exceeded*, followed by South Australia. Once again it should be noted that only one agency is represented in the Western Australia data.

**Table 11: Home Based Care Module**

State	Score %					Number of Agencies
	Exceeded	Met	Met in Part	Not Met	Not Applicable	
<b>NSW</b>	5.9	60.8	3.9		29.4	3
<b>QLD</b>	1.5	89.7	5.9	1.5	1.5	4
<b>TAS</b>	17.6	76.5	2.9	2.9		2
<b>Total</b>	<b>6.5</b>	<b>77.1</b>	<b>4.6</b>	<b>1.3</b>	<b>10.5</b>	<b>9</b>

Table 11 indicates that only three states, NSW, Queensland and Tasmania, have data from the Home Based Care Module. On average, over 77% of the Home Based Care Module standards were *Met* nationally, with a further 6.5% *Exceeded*. Over four percent of standards were *Met in part*, and over one percent of standards were *Not met*. Ten and a half percent of Primary Health Care Module standards were designated *Not applicable*, the majority of these (29.4%) in NSW.

Queensland had the highest number of standards *Met* or *Exceeded*, followed by Tasmania. It should be noted that only nine agencies are represented in total in the Home Based Care Module national data.

**Table 12: Integrated Health Services Module**

State	Score %					Number of Agencies
	Exceeded	Met	Met in Part	Not Met	Not Applicable	
QLD		72.6	19.4		8.1	3
VIC		5.0	90.0	5.0		1
<b>Total</b>	<b>0.0</b>	<b>56.1</b>	<b>36.6</b>	<b>1.2</b>	<b>6.1</b>	<b>4</b>

Table 12 indicates that only two states, Queensland and Victoria, have data from the Integrated Health Service Module. Data represents four agencies.

On average, 56.1% of the Integrated Health Service Module standards were *Met* nationally. Over 36% of standards were *Met in part*, and over 1.0% of standards were *Not met*. Over six percent of Integrated Health Service Module standards were designated *Not applicable*.

There was a significant difference in this case between state data, with Queensland having a significantly higher percentage of standards *Met* than Victoria. However it should be noted that only one agency is represented in the Victorian Integrated Health Services Module data.

#### Performance of agencies against individual standards

Tables 13 and 14 provide information on agency performance against individual standards from the Core and Primary Health Care Modules nationally. Only these two modules are used as there is currently inadequate data to provide an accurate picture for the other modules.

A brief description of the standards as numbered is provided below.

#### Summary Guide to the Standards (Core)

##### **Section 1 Management and Leadership**

- 1.1 Governing Body
- 1.2 Accountability
- 1.3 Effective Management
- 1.4 Leadership
- 1.5 Efficient Administrative and Personnel Systems

##### **Section 2 Planning, Quality Improvement and Evaluation**

- 2.1 Planning
- 2.2 Evaluation
- 2.3 Quality Improvement
- 2.4 Information Technology Infrastructure
- 2.5 Information Management

##### **Section 3 Training and Development**

- 3.1 Appropriate Training and Development
- 3.2 Orientation

##### **Section 4 Work and its Environment**

- 4.1 Work Satisfaction
- 4.2 Occupational Health and Safety
- 4.3 Appropriate Facilities
- 4.4 Appropriate Equipment
- 4.5 Environmental Responsibility

**Section 5 Consumer Rights**

- 5.1 Policy and Resources
- 5.2 Confidentiality and Privacy
- 5.3 Fair Investigation of Complaints

**Section 6 Consumer and Community Participation**

- 6.1 Understanding and Informing the Community of Interest and Other Stakeholders
- 6.2 Addressing Barriers
- 6.3 Support For Participation

Summary Guide to the Standards (Community & Primary Health Care)

**Section 1 Assessment And Care**

- 1.1 Orientation to Primary Health Care
- 1.2 Intake
- 1.3 Accurate Assessment
- 1.4 Planning Comprehensive Care
- 1.5 Continuity of Care
- 1.6 Multidisciplinary Approach

**Section 2 Early Identification And Intervention**

- 2.1 Documentation and Resources
- 2.2 Comprehensive Approach to Early Identification
- 2.3 Accurate Methods for Early Identification
- 2.4 Prompt and Appropriate Intervention

**Section 3 Health Promotion**

- 3.1 An Environment for Health Promotion
- 3.2 Comprehensive Approach to Health Promotion
- 3.3 Coordinated Approach to Health Promotion
- 3.4 Capacity-building
- 3.5 Optional Resource Production and Merchandising

**Section 4 Records**

- 4A CLIENT RECORDS
  - 4.1 Client Record System
  - 4.2 Content of Client Records
- 4B PROGRAM RECORDS
  - 4.3 Program Record System

**Table 13: Core module**

Standard	Score %				
	Exceeded	Met	Met in Part	Not Met	Not Applicable
1.1	1.3	83.8	13.8		1.3
1.2		86.4	12.3	1.2	
1.3		77.8	22.2		
1.4	7.4	82.7	9.9		
1.5		79.0	21.0		
2.1	2.5	55.6	39.5	2.5	
2.2	2.5	44.4	46.9	6.2	
2.3	6.2	56.8	34.6	2.5	
2.4	1.2	59.3	34.6	4.9	
2.5	1.2	60.5	37.0	1.2	
3.1	1.2	67.9	29.6	1.2	
3.2	4.9	75.3	14.8	4.9	
4.1	2.5	82.7	14.8		
4.2	1.2	76.5	22.2		
4.3	1.2	66.7	32.1		
4.4		86.1	12.7	1.3	
4.5		88.5	10.3	1.3	
5.1	1.3	80.0	18.8		
5.2		81.3	18.8		
5.3	1.3	72.2	25.3	1.3	
6.1	1.3	80.0	18.8		
6.2	2.5	82.5	12.5	2.5	
6.3	5.0	63.7	27.5	1.3	2.5
<b>Total</b>	<b>1.9</b>	<b>73.4</b>	<b>23.1</b>	<b>1.4</b>	<b>0.2</b>

Table 13 shows agency performance against individual standards for the Core Module.

Although the clear majority of standards are *Met*, there is some discrepancy between agency performance against the standards, with standard 4.5 relating to environmental responsibility, most often *Met* (88.5%) and standard 2.2 relating to evaluation least often *Met* (46.9% *Met* or *Exceeded*). There were relatively few instances of standards *Not met* or *Not applicable* to the service.

**Table 14: Primary Health Care Module**

Standard	Score %				
	Exceeded	Met	Met in Part	Not Met	Not Applicable
1.1	1.7	91.7	6.7		
1.2	1.7	75.0	18.3	5.0	
1.3		86.4	11.9	1.7	
1.4		81.0	19.0		
1.5	1.7	74.1	22.4		1.7
1.6	3.4	81.0	15.5		
2.1	1.7	71.7	25.0		1.7
2.2		74.6	22.0	1.7	1.7
2.3		86.7	11.7		1.7
2.4		73.3	25.0		1.7
3.1	1.7	75.0	23.3		
3.2	1.7	73.3	25.0		
3.3		66.7	33.3		
3.4		71.9	22.8	1.8	3.5
3.5		17.1	5.7	2.9	74.3
4.1		71.7	23.3	5.0	
4.2		48.3	46.7	5.0	
4.3		43.3	43.3	13.3	
<b>Total</b>	<b>0.8</b>	<b>71.4</b>	<b>22.7</b>	<b>2.0</b>	<b>3.2</b>

Table 14 shows a similar pattern of agency performance overall against standards in the Primary Health Care Module. Although the clear majority of standards are *Met*, there is some discrepancy between agency performance against the standards, with standard 1.1 relating to orientation to primary health care, most often *Met* (93.4% *Met* or *Exceeded*) and standard 4.3 relating to program record systems least often *Met* (43.3%). Optional standard 3.5 relating to resource production and merchandising was designated *Not applicable* in almost three quarters of agencies reviewed. Other than this, there were relatively few instances of standards *Not met* or *Not applicable* to the services reviewed.

## Conclusions

The QIC data base is currently limited as the QIC Program (formerly CHASP) has only been in operation since 1998 and at present it only has aggregated data from accreditation reviews, not other reviews that may have been undertaken outside accreditation for purposes of quality improvement. As the major quality program provider to the non-hospital health sector however, the QIC data base provides an important opportunity to examine the performance of agencies against standards, in addition to monitoring the reviewing the standards themselves. Although the current data is limited, some broad conclusions can be drawn. Comment is only undertaken where at least two or more agencies are represented in a category. In particular the data provides information regarding the two main QIC modules, the Core and Primary Health Care Module.

In relation to agency type the majority of agencies reviewed did not have beds. In general, there was a relatively consistent pattern of performance between agencies with beds and those without. The only exception to this was for the Primary Health Care Module where although the figures are still small, agencies with beds met more standards (13% more) than agencies without beds.

Conclusions regarding agency performance by program area are also limited due to the large number of programs having only limited representation in the data. This will be an interesting set of data to monitor in the future as the database develops. If only the data from those programs represented by more than one agency is examined, most program areas perform relatively consistently irrespective of the module used. The exceptions to this were multipurpose services which performed less well in the Core Module, and Home Nursing, which performed particularly well with the Home Based Care Module. It should be noted however that there were only two multipurpose services represented in the data.

Although there is some variation in performance across the states over the different modules, the data base indicates a high level of compliance with standards across program areas, agency types and jurisdictions. In addition, a small percentage of standards are exceeded. This would indicate that the data-base could be a useful tool for identifying current and appropriate best practice examples for the various modules in most states. The tables indicate that South Australia and Queensland performed better on the Core and Primary Health Care modules respectively, relative to the other states with data from more than one agency. The figures for standards not met were however consistently low across states and territories. NSW had a particularly high level of standards designated as inappropriate, but only in relation to the Home Based Care module.

There was more discrepancy between agency performance against individual standards. In the Core module, there is a range of over 41.6% between the upper and lower scores, the lower score being for standard 2.2 relating to *Evaluation* and the upper score for standard 4.5 relating to *Environmental* responsibility. There were no significant patterns around standards not met or not applicable. There were similar discrepancies with the Primary Health Care module. There is a range of over 50.1% between the upper and lower scores in the Primary Health Care module with the lower score being for standard 4.3 relating to Program Record Systems and the upper score for standard 1.1 relating to Orientation to Primary Health Care. Standard 3.5 was designated not applicable in almost three-quarters of instances. This is an optional standard relating to resource Production and Merchandising.

There are currently only a small number of agencies represented in the data for some of the modules. It will be important however that as the data base develops, it is regularly monitored and the information provided to policy development processes.

**Recommendations:**

- 1. That regular reports could be provided by accreditation agencies both to assist with monitoring the quality of services in the sector, and in order to contribute to appropriate policy development. The Commonwealth and State governments could have a role in progressing this issue.**

# Report of Stakeholder Consultation

A consultation was undertaken with stakeholders including funders, consumers, providers and reviewers to investigate the factors that influence the successful development and implementation of quality frameworks across different program areas and agency types. Professional organisations and academics with an interest in standards development were also consulted. The process for consultation was through focus groups, telephone and face to face semi structured interviews. All states and territories were represented in the consultation.

Service providers consulted ranged from those in relatively small facilities to those who managed service delivery across large districts, areas or regions. Reviewers consulted were from the national QIC program. In addition, over 60 individual key stakeholders were interviewed in the consultation, the majority face-to-face.

The majority of those consulted had extensive knowledge of existing quality review systems both specific to the health and community services sector and more broadly applicable such as building requirements and occupational health and safety. Many had specific experience in one or more quality program - as reviewers, funders or service providers, and in some instances a combination of these. A number had taken a personal interest and experience of quality programs at a service level into policy development / funder roles. For others, the interest was a direct response to the requirements of their current position.

Through the questions asked at focus groups and interviews, a number of themes were identified. These include:

- the importance of standards and their development;
- the role and cost/benefit of accreditation;
- concerns around the delivery of quality programs;
- improvements which could be made to quality programs and barriers to these;
- the specific needs of rural and remote services.

## The importance of standards and their development

Stakeholders were asked to comment on standards in the health and community services sector including their development and use.

All stakeholders believed that standards were important, however the reasons for this range from community expectations and accountability to funders, to being part of a risk management strategy. Comments included: *“Standards define the expectations a community can have”*. *“If there are poor quality services, the health and welfare of people suffer- there is both the personal suffering and an economic cost”*.

Overwhelmingly, standards were seen as a measuring mechanism. They *“assist in identifying what to measure as well as issues around how to measure”*. Standards were seen as important as goals or benchmarks against which organisations could be compared with similar organisations, both internally through self-assessment processes, and externally through external review. They *“give you goals to strive for even if you can’t achieve them...it prevents complacency”*.

Standards *“are a tool, like benchmarking”*. They were important *“because there is a wide variation in practice.... and not all practice is good”*. Use of standards assisted in improving

quality in service provision. This was seen as particularly important in areas such as aged care where there were clear issues of care and protection involved.

Standards did not in themselves, however, ensure quality. Some articulated concerns; *“Does imposition of the standards provide any guarantee? The standards are ultimately important both in the public and the private sector...(but) goodwill will always be a factor in good service delivery”*.

Many commented that standards should be a nationally driven process. The value of standards as a monitoring mechanism which provided accountability for funders was a recurring theme. *“For funders they provide accountability not only in a financial sense but in other ways, for instance in the organisation’s or the agency’s relationship to clients and communities”*. *“(Standards) spell out what level of service (government) expects”*. *“It’s the maximum, reasonable and adequate standards for the money”*. *“Ensuring compliance with standards is more effective than having requirements in funding and performance agreements as there is limited scope to monitor and ‘police’ them...it is also good to place these issues in a quality improvement framework rather than one of monitoring and policing”*. This was particularly the case in the current climate of government stepping back from direct service delivery. *“They are particularly important if purchaser/ provider situations are involved and if the service delivery is at arms length”*.

The role of standards as a management tool was also considered important by many of those interviewed. Here, the standards provide *“a guide for organisations”* and *“a common focus”*. Standards, or rather the processes around their use, give legitimacy to time spent in other than service delivery. Reviewers and providers in particular commented on the value of the standards in *“forcing you to reflect on practice”*. *“They help staff focus on other than clinical matters”*. For management the standards can be used to *“give you the mandate to do things”*. This is particularly the case in an environment hostile to management; for example where there has been enforced internal restructuring or amalgamations. *“They make agencies establish structures that are needed”*.

There was more caution from representatives of professional associations interviewed. They tended to be more defensive of their independence, especially those in private practice. As one representative commented, *“there is a reluctance to be monitored within the profession, or within health professionals generally”*. Some associations have attempted to address these concerns by developing their own standards but using the term ‘guidelines’ rather than standards. Consistent with the use of standards, however, it was commented that *“the best guidelines allow you to measure your practice and the progress of your patients”*.

A number of stakeholders expressed a concern that standards must be current. There is a significant rate of change in the health sector and some concern was expressed that *“standards were always out of date before they hit the ground”*. One of the academics interviewed supported changes in terminology from standards to guidelines (as discussed above) if they assist the process and speed of implementation of standards/guidelines in the sector.

It was generally agreed that standards should be monitored and periodically changed. For some, this was to be a process of constant review and constant change, while for others it was review to a set timeframe, with changes also made within a set timeframe or as required.

#### Development of standards

There was a wide range of views about development of standards. Although there was agreement that *“ownership is the issue”*, there was not agreement about how this should be achieved. For some: *“anyone can write them, what is important is the consultation leading to agreement”*. For others it needs to be *“a ‘bottom-up’ approach to ensure ownership”*. The involvement of consumers was consistently advocated, and a compromise position was also

advocated whereby services, consumers and others were consulted, with a 'neutral third party' convening the process.

The role of government in standards development was also contentious, particularly with key stakeholders. For some, there was little role for government: *"Government standards are punitive"*. For others there was a more significant role: *"They (the standards) have to be independent to have credibility and ownership, but also to cover the minimum requirements for the funder"*. *"The standards after all are part of ensuring that you are getting the service you (the funder) paid for."* *"The funding body has a role to stipulate what it wants for its money"*.

Some believed the government should have a leadership role in the development of standards. As one public servant commented: *"It's risky if the standards are set by an outside body. The problem is that it can cost you more than you can afford to spend."*

There was more acceptance of the government's role in emphasising the importance of standards and other mechanisms for enhancing service quality, rather than government having a central role in standard development or implementation. One interviewee put this very strongly: *"The Commonwealth doesn't know about service delivery and should stay out of such things"*.

In general the majority of those consulted believed that although it might not be in a leadership role, there was a legitimate role for government in the development of standards. The involvement of government is important in the development of standards as they have resources, and they fund services for which the standards are set. There can also be political processes involved in the development and implementation of standards. Not only does the purpose for which the standards are being developed need to be clear, the development process needs to be forward-looking in recognition of *"exponential change in the sector"*. It is important to look at *"what would be the ideal (service delivery) in 5-10 years time...you're here now, how do you know when you are there?"* Government involvement was legitimised as a mechanism to ensure that the *"tax payers' interests"* were taken into account, and also that policy advice is provided so that, as far as possible, standards remain current in the constantly changing health and community services sector. Some commented that government has access to data and can provide policy direction.

In general, regardless of who instigated or designed them, it was recognised that the standards would only be successful if they had ownership by the sector and credibility both within the sector, and more generally in the community at large. The role of consumers, probably through peak organisations, was consistently raised by stakeholders both in the development of standards, and in their implementation through accreditation processes.

Reviewers thought that *"clarity of purpose"*, *"achievability"*, *"relevance"*, *"user friendliness"*, *"clarity regarding the process (i.e., that it is not pass/fail)"*, and *"focus on quality rather than accreditation"* were all important to consider in the development and implementation of standards. Consultation and familiarity with the goals/purpose of the service and consideration of the context, including organisational frameworks, was also important.

Providers, reviewers and key stakeholders agreed that the appropriateness of standards and processes for implementation were crucial. *"Appreciation of the differences between various organisations, e.g., considering non-Government organisations"* was important, as was *"flexibility in interpretation, recognition of varied organisational structures and the capacity for an organisation to express its culture/individuality while meeting a standard of service"*. The need for appropriateness and flexibility in standards and their implementation was particularly stressed by rural and remote service providers and key stakeholders involved with these services. *"There is no template ... There needs to be flexibility to respond to communities"*.

There was agreement that there needed to be extensive consultation processes undertaken when developing standards and this needed to include all stakeholder groups including consumers, probably through consumer peak organisations. Consultation must be undertaken

to ensure the standards and process for their implementation is appropriate. It was said that *“Clinical standards especially must not be developed in isolation of the industry that is delivering them”*, and that in rural areas *“this means (consultation) with GPs”*. Reviewers and service providers stressed their role in the development of standards on the basis that they were the people most involved in accreditation. Comments were made that the consultation also needs to involve specialists both from the appropriate program area, and academics and others with quality expertise, funders, and professional associations. Some reservations were expressed by key stakeholders, that the involvement of the latter could encourage *“vested interests”* and the use of standards for demarcation purposes to *“map out territory”*. In addition, one interviewee expressed concern that it is important *“not (to) just accept what the marketplace says quality is,”* reinforcing the importance of a cross-section of stakeholders in the standards development process.

Key stakeholders stressed the importance of a process for standards development that involved a review of national and international practice to ensure that the standards are pitched at the right level, and that the development process does not *“reinvent the wheel”*. Most thought standards development should take account of the literature, involve consultation with stakeholders and require piloting prior to implementation.

### Evaluation of standards

Although the importance of standards was generally acknowledged, there were a number of concerns around both the form they currently take and the processes around them. For instance how satisfactory the standards are as a measuring mechanism was questioned. *“What does 98% or 75% actually mean?”* Reviewers and providers tended to concentrate on the particular difficulties around using the standards. They criticised some standards as containing *“too much jargon... (was) not accessible, and (was) a barrier to involvement as it required too much interpretation”*. They also raised implementation issues including lack of time and competing demands, lack of resources, variable commitments across jurisdictions. In addition it was said the implementation processes for the standards could mean that reviewers were *“busy putting out spot fires – it’s difficult to get to making the firebreak”*. Other issues for reviewers and providers also tended to be around implementation, including how to set priorities with the organisation, consumers and staff.

There were also some comments from stakeholders on perceived gaps in existing standards. It was stated, for example, that standards should be set for consumer involvement, that there were still no standards for information provision and advocacy; and standards did not adequately cover gender and diversity issues. *“Perhaps modules within modules could be developed. For example develop an information provision module then add gender-specific standards to run with it”*. Another stakeholder thought standards should be developed to reflect the non-health aspects of disability services.

Not all of those interviewed, thought standards should continue to be developed to respond to new program areas and changing circumstances. Some thought there were already too many standards; *“Too many different standards – too many different requirements under funding guidelines”*. In particular, service providers who were interviewed frequently commented on the number of standards that they needed to consider in the operation of their service. Increasingly there are different standards to reflect the different program areas being offered. For large amalgamated agencies offering a wide range of programs this is clearly an issue. It is also an issue, however, for small agencies. They may not offer as wide a range of programs as the larger agencies they also have fewer resources available. One stakeholder commented that: *“(It) would be helpful if the Commonwealth stopped developing standards and spent the money on coordination”*.

Some thought standards were too specific, others thought they were still *“too generic”*. Those who thought standards should be specific thought generic standards *“lack rigor”*, in that *“one model fits all”*. Those who supported generic standards thought they addressed what was required, while reducing the proliferation of standards. The QIC modular approach was

generally supported as a satisfactory response to these concerns, with the Core Module providing the more generic, and the service delivery modules the program-specific content.

The consultation indicated a variety of views on the purpose of the standards and this sometimes led to expressions of dissatisfaction around where the standards should be pitched - the "minimum/maximum issue". The debate was perhaps best summarised by the following comment, *"should you just have minimum standards or maximum standards that are aspired to but never reached? The latter is more (consistent with) a continuous quality improvement approach, but what does following that tell you about where the bottom-line/minimum standard is?"* Some of those interviewed were clear that standards should reflect best practice. They should give an assurance that services are of the *"best possible quality"* but *"best practice is misused... . So many people say their practice is the 'best', but (this is) not as an outcome of a robust process...who says so?"* Others were more conservative, *"standards give a minimum to achieve - and to expect"*.

Many of the key stakeholders, thought it would be desirable for quality programs to look at outcomes rather than process. It was acknowledged that this was difficult, particularly in the primary health sector, however it was commented that: *"There is not enough about doing the right things well". "There is a tendency in the standards to just measure what's easy rather than what's hard... it's important to look at what the customer and the professions value... And there is far more attention given to what the professions value than the customers".* Some thought that although it may be desirable to look at outcomes, this was not realistic. *"Accreditation should ensure that the process is right – looking at outcomes is too hard.....you need to rely on the research that says that the correct outcomes come from certain processes and proceed on the basis of that"*.

Others thought refocusing from process to outcomes was more straightforward: *"Length of stay and morbidity are more important issues, and what people want to know".* In any other business *"how could you operate without information about outcomes?"* *"Quality programs have gone with what's convenient and easy, not necessarily with what should be done"*.

## The importance of accreditation

Key stakeholders were initially asked whether they thought formal accreditation was important. They were then asked about the costs and benefits of complying with standards or participating in an accreditation process. Reviewers and service providers were asked to comment more generally on quality review processes.

Unlike a similar question regarding standards, to which there was a clearly positive response, there was significant equivocation in relation to accreditation. Accreditation should be an *"audit for quality", the "accountability beyond the organisation"*. One interviewee commented: *"I would like to say lots of positive things about accreditation, but in fact I'm not sure. Is it an adequate monitoring exercise?"* Others put this more strongly: *"Accreditation should be a useful process but it isn't as it is done at the moment", "accreditation doesn't guarantee anything... need other checks and balances", "it conveys a false impression for the public. It means very little"*.

There was agreement that the implementation process for the standards should have a strong continuous quality improvement focus. There should be the *"capacity to go above and beyond the standards"* and *"recognition – especially of innovation"*. Doubts were expressed however at the role accreditation had in this. In fact there were a number of comments from all categories of stakeholders that accreditation could be an impediment to continuous quality improvement. Negative comments included: *"(Accreditation) can lose the momentum of continuous quality improvement."* *"It is an end in itself, and not a means to an end as it stands at the moment"*. If undertaken as an end in itself, rather than as part of a continuous quality improvement process, it was agreed that an accreditation process can reduce commitment to addressing quality issues. The external review in particular can have inappropriate emphasis

and be resented by staff as *“a distraction from the agency’s central purpose”*. To be successful, an accreditation process must be seen to have substance and value for the service and for those who use it.

The question of whether accreditation should be mandatory in the health and community services sector, or for sections within it, was particularly contentious. There was more support for government ensuring agencies participate in quality improvement programs, rather than focusing on the achievement of an accreditation certificate. There was however, support for mandatory accreditation in relation to minimum standards, or where there were issues of care and protection such as in aged care. Key stakeholder comments included: *“If you don’t meet minimum standards you shouldn’t practice”*, and *“you should look at mandatory standards in key areas of performance”*. Another stakeholder expressed the belief that *“standards should be national, minimal and mandatory, with minor adjustments for state requirements”*.

These sentiments raise a number of issues including the issue of non-compliant services, (i.e., services that do not comply with the standards). One of those interviewed commented that: *“(There is) a clear benefit in being accredited if it means you don’t lose your subsidy”*. Others however thought the issue not so black and white: *“At what point is funding threatened?”* One key stakeholder disputed the punitive approach to encouraging compliance with standards on the basis that it was important to remember that *“the size of the penalties is not the deterrent, but getting caught is”*. The aim of accreditation as part of a quality improvement process must not be forgotten.. Non compliance means that the review process has identified problems which the service must now address. There was agreement that monitoring and review is crucial, and that the focus should be on the process and the frequency of inspection. During the consultation, recent issues around nursing homes were often cited as an example of this. As one of those interviewed commented, *“It’s a dangerous notion that accreditation for three years makes things okay”*.

What is achieved?

If there appear to be significant concerns about the value of accreditation, what does it achieve?

Those supportive of accreditation thought it provided important recognition of a service’s performance, and that this was important to all stakeholders, including the service staff and the community they serviced. Positive comments around accreditation included, *“important as a visible demonstration that standards have been met”*, *“a validation, or recognition for work being done, which is externally very important”*. *“It means you should be able to assume something about the service being given... or that they are being assisted to work through to that standard”*. *“If you didn’t have accreditation to aim for you would be overwhelmed by service delivery... It makes you focus on the bigger picture, no matter how hard that is”*.

The accreditation certificate was seen to provide a public statement of a service’s commitment to quality. Some key stakeholders also commented that accreditation could be used as a marketing tool in the current competitive environment. An accreditation process should show an agency, and the community within which it operates, where it stands relative to its peers. Some thought this could then provide a ranking of similar agencies in the sector in order to encourage competition around quality. Others thought this was inappropriate, and that quality and accreditation should not be about ranking or marketing. The competitive environment implied by this suggestion was questioned by some, while others asked if accreditation was used in marketing: was this sensible or effective? As two interviewees commented: *“In community care you don’t usually get the option to shop around”*, *“Why does the government want us to market ourselves? There are no shortage of customers, there are waiting lists”*.

Accreditation provides an external assessment of a service, and this in itself was generally commented on positively. Ideally accreditation added to internal processes which needed to take place to ensure continuous quality improvement. A review by peers gave credibility to accreditation and also was an important factor in making the accreditation process itself

useful. *"It provides a dialogue opportunity between agencies". "The external process not only provides credibility but fresh eyes from the outside".*

Rural and remote services also commented that they appreciated the concept of peer review, however they had particular difficulties regarding training of staff as reviewers and their time release to undertake reviews. One of the respondents explained a preference for peer review as follows: *"As a manager I felt that there was more rapport between us (the review team and manager). It makes a difference knowing they are in the same kind of business - it makes it more realistic. (One quality program) is predominantly designed to fit hospitals so you are constantly redefining the standards which means continually explaining community health".* This reinforces not only the value of peer review, but also the importance of appropriate review teams and in fact quality programs for the service to be reviewed.

The rural and remote service respondents (and others) also commented frequently on the review process as either a tool for change management, or as a process for the inclusion of quality in service delivery. The following statement reflects the change management sentiment: *"It is well worth participating as it is a tool for driving change, it is slow and does need education, but it is well worth it".* There was a pattern to these different responses to identifying the gains of the review process according to states. Those from NSW and Queensland mentioned change management as the major benefit, while the others generally emphasised the continuous improvement or service delivery aspect. This may well reflect the different approaches taken to encouraging services to undertake quality reviews in the different states.

Rural and remote services in particular had issues around isolation and high staff turnover - the latter was also raised by other stakeholders. Several comments by respondents from rural and remote services included the importance of the review process as contributing to bonding between staff. One respondent stated: *"For me the sign of success was the bonding that happened among the staff as a result of the review".* One suggestion for improvements to the delivery of quality programs to rural and remote services was to provide *"more opportunities for staff bonding during the review process. Our organisation includes five hospitals covering 220 kilometres".*

Accreditation was seen by some key stakeholders to be an invaluable mechanism for government monitoring of services. One funder commented that they *"like (the idea of) an objective third party coming in (to agencies). As a department we couldn't do it...people wouldn't be honest... We're the funder!"* Others, however, stated that standards and accreditation processes should not be used as an accountability mechanism for government. Concerns expressed were either that standards and accreditation processes may be inadequate or inappropriate for the task, or that this could undermine the ultimate aim of improving the quality of services by encouraging agencies to participate in a continuous quality improvement process. Agencies would have a vested interest in hiding shortcomings, and not seeking assistance and support through the accreditation process, if the accreditation process was perceived to be tied to a threat to funding. Accreditation could become *"just a back covering exercise for some funders".*

Although there were concerns about accreditation, most stakeholders ultimately acknowledged that accreditation could be worthwhile and *"it may be the best system we've got".* The key to a useful accreditation, however, was the purpose for which it is undertaken. *"They should not just be about a certificate on the wall".* There was also general agreement that *"doing a snapshot"* was not a useful process.

## Cost/benefit of accreditation

There was not a consistent pattern of responses by those consulted as to the balance between the costs and benefits of complying with standards or participating in accreditation processes. When asked: *“What are the costs and benefits of complying with standards or participating in an accreditation process?”* most commented adversely on the cost. This was particularly the case for smaller agencies. There were however, differing perceptions as to the relative costs of the different quality programs.

Concern around the cost was not only focussed on the direct fee for participation in the program, but also the overall cost in time and staff resources devoted to the process. In addition, back-filling positions in a peer review process which required reviewers to be absent from their own service for blocks of time while they reviewed others, was an issue for particularly smaller agencies and those in rural and remote areas. One manager of a rural/remote service commented: *“Due to staff turn over of reviewer trained staff, this service lost a knowledge base, skills and support for the program amongst staff”*. In a similar vein another manager indicated that *“services can’t afford to train staff as reviewers any more, the need to backfill their position whilst training and reviewing is too difficult”*.

Nonetheless some of those consulted, including reviewers, key stakeholders and service providers, expressed their belief that the experience reviewers brought back to their agencies ameliorated this cost. They argued that reviewing should be seen as a professional development activity. In smaller services however, there was often a view that although this might be the case, it was a luxury they could not afford.

Complying with a proliferation of standards was seen to be an issue for some of those consulted, in particular service providers. *“There is a proliferation of programs causing repetition in activities and a waste of time spent without getting any new information”*. There were more comments however on problems that arose when implementation processes for standards placed an unreasonable pressure on services, rather than in the proliferation of standards themselves. This appeared to be particularly the case for smaller agencies or those in rural or remote locations.

Many of the respondents from rural and remote services mentioned costs as a barrier to quality assurance. There is a perception that the particular issues affecting rural and remote services are not recognised and there is no sense of real support. Evidence cited for this view included, increased costs of reviews, particularly when reviewers are bought in from other states, and site education costs.

The need to provide accommodation in a rural or remote location can significantly add to the cost of accreditation. One respondent stated: *“We got caught; it cost us close to \$70,000 what with \$6,000 to join and \$24,000 per year and then all the accommodation, taxi’s, food even where we had already provided it, for four teams cost us another \$40,000. The next time we only used one team with limited site visits but it was not nearly as good”*.

In a number of cases there were comments from rural and remote respondents in particular, that their service had, for example used both QIC and one of the other review processes such as AQC, ISO or EQuIP. The latter was chosen by the larger organisation, but QIC was the preferred choice by those involved in community health service. Several of the respondents commented that this might be difficult to do in the future as the availability of funding for accreditation becomes more limited. *“They are prepared to pay for one, but it is a battle to get dollars for both, and that is going to be harder in the future. Everyone is budget conscious”*. Another respondent said: *“Up till now our involvement was funded by the department; \$7000 - \$8000 is too much (for us)”*.

All programs were criticised for the cost of participation. Service providers were clear that they expected value for money from quality programs and recognition in the fee charged of their service’s resources, and the financial climate in which they are operating. Many were not

convinced that this was currently the case. Reviewers also expressed concern around costings, and in particular questioned whether quality programs could continue to train them without additional resources. The comment was made: *"They can't rely on our goodwill, organisations are cross subsidising us when we train, or individuals are, if they are not employed"*. A further impact of under resourcing commented on by one respondent was: *"The funding restraints mean that we can't afford a designated position for client services quality"*.

Generally, funding is not available for compliance with standards. Government considers this should be part of the general operation of the service and funded within the existing budget. Resentment can result from money being spent on quality review processes that would otherwise go to service delivery. As one funder interviewed commented: *"We don't fund accreditation directly, it comes out of service provision; and that's an issue"*. There is however, a significant financial commitment involved for services wishing to participate in a quality program. For small agencies in particular, this was seen to be an unreasonable burden. In addition, *"If there's a choice between service provision and quality programs, service provision will win every time"*.

## Concerns around the delivery of quality programs

Those involved in the consultation were asked to comment on, and compare, current quality improvement approaches in the primary health and community services sector.

The major programs in the health and community services sector are QIC and ACHS, with ISO and AQC having a smaller role. As the majority of those consulted were identified through the QIC Program, there was a disproportionate emphasis on the QIC Program. However, a number of stakeholders also had either direct or indirect experience of other quality programs. The current move to amalgamating service provision across a number of program areas, often resulting in an agency configuration that combined acute and non-acute facilities, increased the likelihood of service provider stakeholders experiencing more than one quality program.

There were concerns about all quality programs and about accreditation processes in particular. In part dissatisfaction with quality programs reflected different perspectives on the role of accreditation, as discussed previously. Some were clear that an accreditation certificate indicated no more than that the agency had participated in a quality program and was working towards a standard. Others thought accreditation should mean that an agency had attained a certain standard. Dissatisfaction with quality program providers then arose when, *"you get accredited agencies who still deliver poor services, and you shouldn't"*.

Some quality programs focus more on accreditation than others, and accreditation, in particular mandatory accreditation, highlights a number of important issues in the implementation of quality improvement programs themselves. Perhaps the most fundamental of these is the concern held by some that *"you can't drive quality through accreditation programs"*. In addition, some stakeholders were concerned about the monitoring of the quality review process. As one put it *"who accredits the accreditor?"*

### Appropriateness of choice of quality program

The cost of individual quality programs was cited by a number of respondents as potentially reducing the appropriateness of the selection of the program: *"Cost is a consideration"*. One respondent from a rural/remote service commented that: *"In NSW huge financial pressures have created an environment where decisions are based on costs and not necessarily the appropriateness of the accreditation system"*. In an integrated agency in particular, a single program may be chosen when two parallel processes might be more appropriate. Alternatively only the least costly program may be selected to comply with requirements, rather than the program most appropriate to the service.

Several respondents mentioned the problem of being integrated into a hospital setting and losing the ability to choose an appropriate review process for community health services. In addition, in some instances the make-up of review teams was inappropriate to the service being reviewed. A common example being reviewers with only tertiary hospital experience being used to review small rural facilities.

The QIC program is underpinned by a strong set of primary health principles that a number of stakeholders said, supports the aims of the health and community sector. Certainly, the traditional clients of the Program - community-based organisations and in particular community health services - sit well with the collaborative and consumer and community focus offered. More recently, ACHS, through its EQuIP program, has moved in a similar direction in its traditional hospital client base, not to the same extent however possibly due to the more conservative and hierarchical nature of the hospital sector.

### Costs

As discussed above, all quality programs were criticised for the cost of participation. Not only were additional resources sought for participation in quality programs, suggestions were also made to reduce the cost of the review process itself. There were comments both about streamlining the review process, while at the same time concerns were expressed that the credibility and rigor of the process should not be jeopardised.

### Standards

A number of concerns around the standards have already been discussed. In particular concerns around the current emphasis on process, particularly in the community health sector, were raised.

Concern was also expressed that quality programs should ensure that their standards are current and appropriate to the service being reviewed. Standards and processes for their implementation should be flexible. Particular issues in regard to rural and remote services have also been discussed previously. There was a perception by many of those consulted that the standards used for rural and remote services have been set for or by, major teaching hospitals at a level that makes it impossible for rural services to attain. *"They just can't do it and if the full standard was imposed the service would have to close". "Size isn't the only factor". "The context for expectations in rural services needs to be taken into consideration .....urban things do not necessarily relate to rural area"*.

Some respondents were concerned that if the standards are set too high or implemented inflexibly, the service may have to close and the consumers (or residents) will need to move. They thought there are social issues to consider and that closure of services results in community dislocation. *"But the community might be keen for the service to continue and at the standard at which it is being offered". "You need to be careful where you set the bar".* The development and implementation process for the standards is therefore particularly crucial in rural areas. *"Standards should be developed and based on managed risk"*.

Concern was also often expressed about those quality programs, such as ISO, that were seen to lack a philosophical framework and to be *'content-free'*. Comments included that a quality program based on a manufacturing model of industrial process was shallow and inappropriate to the health and community services sector. Others thought the emphasis in quality reviews on an examination of process alone was legitimate. Quality programs that focussed exclusively on a snapshot of process were sometimes referred to by those consulted as a *'tick-box'* or *'clipboard'* approach to reviewing. One key stakeholder commented negatively on an extreme example of this where a quality program was being delivered as an audit through a website with no direct contact between the service and reviewers.

The criticism of an over-concentration on process however was also levelled at both the ACHS EQuIP Program and, though to a lesser extent, the QIC Program as outlined in the section on evaluation of standards. Examples of concerns included: *"ACHS has a very*

*structured approach in hospitals, but people want to know infection rates, not how many pharmacists there are”; and currently “there is not much about effectiveness in service delivery, it is more about the credibility of the process”. One respondent concluded that quality programs should “not just be process driven but also to look at outcomes”.*

#### Implementation of review processes

A number of concerns were raised about the review process itself, both as an effective monitoring exercise, and regarding the role of reviews in a continuous quality improvement process. Perhaps some of the concerns expressed regarding accreditation and its role (or lack of it) in promoting continuous quality improvement could be addressed by improvements in quality program implementation. Certainly accreditation must be seen as a credible process. As one stakeholder interviewed commented: *“Accreditation is now almost like time and motion study... it has to have substance rather than be a ‘tick and flick’ process”.*

Concerns were expressed regarding review teams and their training, experience and appropriateness to the facility being reviewed. Other criticisms of quality processes included: *“Surveys are not frequent enough to have an impact on everyday working lives... the agency just winds up for the review and then winds down again”.* If quality programs put more effort into integrating the accreditation review into a continuous quality improvement cycle, this should not occur. Quality programs should offer ongoing advice and support to agencies through regular contact. Reviews and other activities should be undertaken between accreditation reviews to encourage a continuous quality improvement culture.

In a sector that has significant constraints on resources, the need for efficient and rigorous processes is particularly important. Some service providers commented that there was unnecessary duplication in the review processes; for instance, verification sought both through interviews and through documentation that a certain standard had been met. While some thought that such duplication was essential to the rigor of the review process in that it ideally provided triangulated verification, resourcing issues mean that review processes should have as little duplication as possible. Processes must be developed to reduce duplication both within individual quality accreditation programs and between the different programs in the sector, as far as possible without undermining the rigor and credibility of the process.

#### Competition between quality programs

Difficulties relating to duplication across quality programs frequently arose. Although this was particularly the case between the QIC and ACHS programs, it was also raised in relation to other standards and programs, such as Disability Standards and HACC. Comments included: *“The quality standards/programs need to be better integrated.... really hard especially for small services to respond to all the demands”.* *“Our centre gained something after doing disability as separate program, but could have done QIC with a few extra indicators”.*

Duplication was a particular concern for agencies that have amalgamated acute and non-acute areas. The non-acute sector is more likely to be in the QIC Program while the acute sector is more likely to be with ACHS. Each sector tends to carry its respective quality programs with it into the amalgamated agency.

For some this is not an issue, while for others, running parallel processes can be seen a cumbersome and not consistent with good management practice. Costing issues also arise as discussed earlier. In such situations some managers see it as essential to make a choice as to which quality program the amalgamated agency is to adopt. Almost inevitably the hospital model will dominate this decision, because it is seen as the dominant party in the amalgamation both culturally and in terms of resources. As one service provider said: *“The CEO and nursing director make the decision and we tag along. They have a bigger budget even though we have similar staff numbers”.* In addition, the manager of the amalgamated agency is more likely to have had personal experience of the ACHS process rather than QIC. Few managers of such an agency will have come from the primary health sector.

Some stakeholders expressed concern at a perceived 'blinkered' approach to examining alternative options for addressing quality issues, even where this was in their agency's interests. Some managers see themselves as either ACHS or QIC people, and make decisions on the quality program their agency should adopt based on this, rather than what might best fit their agency's philosophy or organisational configuration. Services are however unlikely to be committed to imposed and inappropriate quality program. In such circumstances the accreditation process is more likely to impact unfavourably on its day-to-day operation.

Although they have traditionally serviced different sections of the sector, QIC and ACHS programs are increasingly seen to be in competition for the health and community services sector particularly for integrated services. There are still significant differences in approach and ideology, notwithstanding the development of the ACHS EQuIP process. However, the two programs also have important similarities. There is a clear perception in the sector that this competition is not desirable and that a more cooperative model should be developed between the them. A number of mechanisms could be investigated to address this issue.

## Improvements which could be made to quality programs and barriers to these

Respondents were asked how quality programs could be better implemented in the sector and what were the barriers to implementing changes. Some of the suggested improvements to the delivery of quality programs are outlined in the section above. Other suggestions are developed more fully in the following sections.

### Cooperation between quality programs

More cooperative arrangements between quality program providers, and in particular QIC and the ACHS, need to be developed.

ACHS and QIC could form a partnership to deliver accreditation and support quality programs across the sector, although this is probably not likely in the short term. Both are non-profit organisations, however they have different approaches and capacity and there would be commercial considerations that would need to be worked through. In addition there are still significant differences in the principles from which each operates.

There is currently a protocol agreement between ACHS and QIC that attempts to address some of the concerns regarding duplication and competition. It does not, however, appear to be effective in reducing the perception of unnecessary complexity and duplication. One provider commented that they thought "*the EQuIP /QIC protocol agreement wasn't respected during (their) survey*". A clearer and binding agreement is required. This could, for instance, provide a framework for cross-recognition of prior accreditation in other quality programs, not just ACHS and QIC, but also programs such as HACCP and ISO. As one provider commented, such a system of recognition between the various programs could be developed "*so that for instance HACCP could say, you're in the QIC Program so you don't have to do all of ours. They all have the same core principles*".

Where it was appropriate for more than one quality program to be undertaken by a single agency, the protocol could ensure that duplication was kept to a minimum. The protocol could also ensure services are fully aware of the various quality programs options available before making a decision as to which is the most appropriate for them.

Each program could use the standards and indicators developed by the other (or others) to reduce fragmentation, and better respond to the needs of individual services within the sector. Even if a partnership agreement cannot be reached, ACHS and QIC could jointly develop standards that could then be used in both programs. Apart from the duplication and confusion that can be caused by two or more sets of standards being developed for the same program area, this process is unnecessarily resource-intensive for the quality programs themselves.

Another mechanism which may increase the efficiency of quality program delivery to services undertaking more than one quality program accreditation could be the pooling and multi-skilling of reviewers. The profile of ACHS reviewers appears to be around senior management in the hospital sector. QIC reviewers reflect direct service delivery program areas in the primary health sector. A small number of reviewers have been trained to review in both programs. The possibility of training more 'dual' reviewers to be used by either or both programs should be explored further. The logistics of this - training, payment, appropriate configurations for review teams and ideological differences - may be complex but there could be considerable return. Not only could duplication of accreditation processes be reduced, but also the value of the advice and support given to services being reviewed is likely to be enhanced by the broader perspectives developed. Such a process may also reduce the traditional cultural divisions between the sectors.

#### **Recommendations:**

- 2. That quality program providers establish cooperative arrangements aimed at reducing confusion and duplication in program delivery.**
- 3. That quality program providers develop, strengthen and monitor, as appropriate, protocols around the delivery of quality programs in the sector.**
- 4. That information on protocols that have been developed be made available to service providers.**

#### Standards

There were a number of concerns expressed around standards, including the possibility of a proliferation of standards and processes for their implementation placing undue pressure on agencies. The issue of whether compliance with standards should be mandatory was also controversial.

Contradictory views were expressed as to whether standards should be maximum or minimum. However there was more support for mandatory compliance with standards in instances where minimum standards had been identified, and in particular where there were issues of care and protection of the vulnerable. The role of consumers and concerns that accreditation is a meaningful process for them was also raised.

Whether standards should focus on process or outcomes was also controversial. There needs to be a better connection between accreditation, continuous quality improvement and public outcomes. This needs to be addressed through a review of accreditation processes and the standards themselves. Although there are clinical indicators for the hospital sector, there is not an equivalent for the primary health sector. The Commonwealth should consider funding the development or redevelopment of standards and indicators that better reflect outcomes in the primary health sector. Although few thought outcome standards would not be desirable, comments were made that these might be difficult to identify in the sector.

Although some gaps were identified in the current standards, these could be addressed by the addition of some specific indicators to existing standards systems, rather than the development of new additional sets of standards. Alternatively the need for new standards may be circumvented by identification of current best practice examples appropriate to new areas, which can then be used in conjunction with appropriate existing standards. This could assist with addressing the issue of standards proliferation and move the focus for quality programs and government from standard development to implementation processes and resourcing issues.

#### **Recommendations:**

- 5. That an appropriate framework to guide further standards development for primary health and community services be developed, taking account of existing frameworks and other relevant proposals, to prevent the proliferation and duplication of standards across the sector.**
- 6. That an appropriate mechanism to review and monitor standards development for primary health and community services, that includes stakeholder interests, be established.**
- 7. That the development of outcome standards for the community health sector be re-examined.**

#### Implementation of review processes

As discussed above, a number of concerns were raised regarding implementation of quality review processes. Suggestions were made around streamlining the accreditation process, improving the quality of reviewers, and better integrating the accreditation process into a continuous quality improvement approach.

Comments were also made that although the standards were seen as a measuring mechanism this appeared not to be reliable. Some thought the scores were not meaningful, others were thought discrepancies between reviewers and review teams should be addressed.

#### **Recommendations:**

- 8. That quality program providers ensure that review teams are appropriate to the service to be reviewed.**
- 9. That quality program providers ensure that they provide advice and support to agencies within their programs, both through the formal review process and at other times.**
- 10. That quality program providers have appropriate mechanisms in place to ensure their programs are rigorous, including reviewer training and monitoring of the review process.**

#### Reporting requirements

Another issue for services is around duplication of reporting requirements. Funders often have different requirements for each of a number of programs being delivered by a service. In addition, there is likely to be more than one funder involved in any service. One service provider commented: *"(It needs to be recognised that) we have 34 funding lines in the organisation all with different demands"*.

Governments require services to report regularly against their service agreements and this can be a disproportionate burden for smaller services particularly if there is a small amount of funding received. There was also some scepticism from a number of those interviewed, both within and outside government, as to the extent to which this data was productively used. Concern was expressed at the 'silo' approach to reporting requirements within government funders and between government and quality program providers.

One response to this received significant support during the consultation. It was proposed that a process could be trialled whereby service agreements would be treated as an agency's standards for the period of the agreement. This could substitute for participation in a quality program for the agreed period. A quality program such as QIC could then monitor and review the service's performance against the service agreement/ standards. To ensure there were

not significant 'gaps' between complying with current standards and such agreements, it would necessary to have a preamble which included requirements around core principles such as access, equity, participation and planning. It should also be agreed that the process undertaken by the quality program provider is not just a monitoring process, but that services would receive support and advice.

Consideration should be given to greater integration of reporting against standards into ongoing services agreements. A quality program such as QIC could then monitor and review the service's performance against the service agreement/ standards. However, in many cases this would require significant modification to the program and funding guidelines which determine the form of existing service agreements.

Nevertheless, the greater linkage of quality programs with service agreements has the potential to reduce transaction costs to agencies while at the same time increasing the emphasis on participation in quality programs.

**Recommendation:**

- 11. That the integration of quality standards and review process into service agreements be piloted and evaluated by quality program providers.**

Resourcing issues

With the defunding of the Australian Community Health Association and QIC by the Commonwealth, there is now something of a vacuum in the coordination and resourcing of national initiatives for standards development, monitoring and the promotion of quality improvement for primary health and community services. While the establishment of the Australian Council for Safety and Quality in Health Care is an important step in this respect, the Council is strongly focused on the acute sector. Similarly, the development of an accreditation system for general practitioners, while an important for improving quality in primary care, has little relevance to the range of community and primary health agencies funded through State and Territory governments. It is important that appropriately resourced national coordinating structures and processes are put in place to address this gap for publicly funded primary health and community services.

The majority of those interviewed thought government should make a contribution towards the cost of participating in quality program activities. This is particularly true for the community health sector where funding constraints are extreme, and the size of agencies means that there is little capacity to redirect resources away from direct service provision. *"They need additional money to be in the quality programs and they need the infrastructure for their delivery". "If the government is serious it needs to provide significant resources."* One of the academics interviewed put a figure of *"\$160m or .05% of the budget is needed to institute quality programs in health"*.

**Recommendations:**

- 12. That an integrated approach to quality improvement standards for primary health and community services be developed and the resourcing implications for coordination, monitoring and development be investigated.**
- 13. That appropriate arrangements for funding agencies to be involved in quality programs be investigated.**
- 14. That government give particular consideration to ensuring that smaller agencies and those in rural and remote areas in particular, have a capacity to participate in quality programs.**

## Information provision and support

Access to information is crucial to quality improvement, yet a number of stakeholders commented that information on quality issues was hard to obtain, particularly for rural and remote services. In addition, *“the discussion around quality programs is so esoteric...it’s hard to translate it into my world”*. Concern was also expressed at the lack of understanding about accreditation generally and what it means for a service to be accredited. When referring to Aboriginal services, one of the respondents pointed out that there was little knowledge of the difference between continuous improvement and accreditation. The respondent noted that: *“This is a real barrier, particularly as there is community resistance due to lack of understanding of the process”*. It was suggested that: *“It needs more involvement and networking to involve community and clients and to create an understanding of the process, and a demonstration of the benefits”*. It is unlikely that this is unique to Aboriginal services.

Information provision is also closely connected with education and training addressed below.

Current and appropriate information must inform quality programs, reviewers, services, consumers and the community at large. Reviewers and consumers are not able to adequately participate in quality improvement processes unless they are informed about current practice around service delivery, options that may be appropriate and, ideally, mechanisms for achieving alternative approaches. Reviewers commented on the need to get together to *“get an update on what is going on”*, reflect on issues and to integrate ideas resulting in a more cohesive approach. *“I want to find out what they say to services so that we don’t get the situation where people say ‘but the other reviewer said that’. It is important to have a uniform response.”* The difficulty of getting information on quality issues was also a common theme from key stakeholders.

Although there was some scepticism about how they are identified, an important factor in continuous quality improvement is the identification and use of best practice examples. A number of those interviewed expressed concern at the difficulty of obtaining information on appropriate and current best practice examples. In a sector of exponential change such as the health sector, ensuring examples are current is particularly important. In addition, examples are often drawn from international experience and, while this might be useful, there also needs to be more identification of Australian best practice examples, including those for rural and remote services.

Quality programs should have a major role in information provision. Although both ACHS and QIC support continuous quality improvement and believe they provide ongoing advice and support to their client services, this is not a view supported by many of the services themselves. Currently, many agencies believe there is inadequate contact from their quality program providers between reviews. As stated previously, a focus solely on reviews undermines continuous quality improvement. Quality programs should not only offer advice at the time of review, but ongoing support through a variety of mechanisms including direct contact, information provision and networking opportunities.

The Internet is particularly suitable as a cheap and readily accessible distribution point for information. Key stakeholders, service providers and reviewers all expressed an interest in information provision using technology such as email and internet. Reviewers also raised the issue of delivery of information and training using technology both for themselves and their services.

All of the major quality programs in the sector have web sites. Better links could be established between appropriate sites, and other options such as chat rooms could be particularly useful in providing networking opportunities for rural/remote services.

The technological approach should not preclude quality programs and government exploring other possible mechanisms for information provision, such as newsletters (although these could also be distributed over the Internet), seminars, and so forth. There are obviously

resourcing issues which arise from all the options, particularly those involving face-to-face contact. Once again, this is exacerbated in the case for rural and remote services. Resources for additional initiatives are unlikely to be available at the individual service level, or from the existing quality programs. Additional resourcing from government would need to be made available to further develop information provision.

Commenting more generally on information provision, one stakeholder stated that: *"Australians are very ignorant, and very trusting of their health services"*. The option of adopting the United States model, whereby the public can have access to detailed information on hospitals and other health providers, including infection control procedures, specialisations and success rates of interventions, was also raised.

#### **Recommendation:**

**15. That information resources on quality improvement and assurance be developed for primary health and community services, including appropriate best practice examples, particularly for those in rural and remote areas. The funding arrangements for this development be investigated by the State and Commonwealth Governments.**

#### Education and training

Education and training around the importance of continuous quality improvement in the health sector was seen by many of those interviewed as central to improving the quality of health service delivery. A number of the respondents, mainly in rural and remote services, considered that quality assurance was not clearly understood by staff members at their organisation, and that this was exacerbated by their remote locations and the dearth of appropriate education for services in rural and remote locations. One respondent said: *"More education for staff on the process and quality assurance would have been useful. Education and access to trainers in remote areas is limited"*. Another respondent said: *"Ownership by staff is crucial - therefore more staff education is required"*. *"Ongoing training to overcome loss of skills due to staff turnover"* was also mentioned as a particular difficulty in remote services.

A 'champion model' was proposed by one of those interviewed in which key players from different professions need to be educated and then form teams to educate others in the field. Another suggestion was: *"A common first year for all those who work in the health sector (would be a positive thing)"*. This could help health professionals *"speak the same language"*, and could assist with eroding the cultural barriers that many thought existed within the sector. In particular the hierarchical nature of the health sector was frequently cited as a barrier to change. Although supportive of training, one interviewee reflected that: *"Training will help, but the sector knocks people into what they want them to be"*.

If it was not possible to have a common first year, it was suggested that a program should be developed whereby people currently working in the sector could undertake a unit of training related to quality, and to which they could link their experience in the sector. Part of this unit could be to work on a practice improvement project.

A number of service providers interviewed expressed concern at the quality of reviewers and their capacity to provide support and advice to services. In addition to concerns that review teams were not always appropriate to the service (for instance those with tertiary hospital experience reviewing small rural services) some reviewers were thought to have inadequate experience, and others had 'hands on' experience gained some time ago. Others commented that: *"Quality coordinators (reviewers) are frequently auditors where they should be teachers"*.

The selection and training of reviewers itself needs review. Different quality programs and different program providers offer different training to their reviewers. Quality programs should review their selection and training of reviewers. They should also ensure that review teams reflect the needs of the service being reviewed.

## Recommendation:

### **16. That incentives be provided to academic institutions that provide training on addressing quality issues in service provision for the health and community services sector.**

#### Leadership

Leadership is crucial to the successful implementation of quality programs. Management must be committed to ensuring that continuous quality improvement is integrated into all aspects of the service's operation. If the impetus for the process comes from further down the organisation, there is a greater danger that it is marginalised from day-to-day activity. Although the managers interviewed during the consultation were deeply committed to quality improvement, they were not a random sample, and are not necessarily representative of managers generally. Many of those interviewed commented that management is generally ignorant about quality issues, and not interested in driving the process within their organisations. Experience in quality is not seen as an advantage for a career path. In addition it was commented by one of those interviewed that government is providing *"the wrong incentives to managers"*. Quality is currently not an important factor in how a manager's performance is judged.

Lack of management involvement is also perhaps part of a style of 'hands off' management. Quality programs will not be successful, however, unless management shows it is committed to the process. Management might be persuaded to take more of an interest in quality issues if the cost-benefit was clear. Establishing the cost-benefit of participation in quality programs, however, is difficult. *"If efficiency is improved as it should be, then it makes sense that it is a benefit....It is common to minimise risk, and minimising risk is one of the benefits of participating in a quality program"*. Several of those interviewed used the term 'risk management' when talking about standards and accreditation. One approach, which may encourage managers to take an interest in quality issues within their organisations, might be to market this as part of a risk management strategy. This is likely to be particularly useful in the hospital sector where risk management is accepted and the repercussions of adverse events seen as more serious.

Many of those interviewed also commented unfavourably on the lack of leadership and commitment to quality improvement from government at all levels. There is not seen to be enough encouragement from government. There is *"little reward for having gone through it (accreditation). An organisation may have changed but (there is) no recognition from the department"*. This view is reinforced by a perceived lack of resources provided for services to pursue a quality agenda.

Government is also accused of being disproportionately concerned with the hospital side of the health sector to the detriment of the primary health sector. Some thought the Commonwealth had abrogated its responsibility to ensuring quality in community health: *"It is a Commonwealth responsibility, but they see it as a state responsibility because they don't fund primary care"*. Other comments included that government saw health as hospitals and GPs, and did not recognise the role of other sections of the sector. This is understandable given the size of the budget allocated to the former, but this approach does not reflect the importance of the primary health and community services sector in reducing pressure on the hospital sector, and hence reducing costs.

There was general agreement that it would be desirable for quality issues to be addressed nationally. One stakeholder proposed that a national standards and monitoring program would be desirable that at least *"goes into all facilities or institutions within a sector; public or private..... It could, for instance, cover all prisons, or all hospitals"*.

Government at all levels must show it is committed to the delivery of quality services across the sector, including addressing the resourcing issues. If government is to take a greater role,

it would be desirable to have a coordinated response. Those supporting an enhanced government role, cited the Quality and Safety Committee as an option for coordinating a government approach.

**Recommendations:**

- 17. That responsibility for coordination of quality improvement for the health and community services sector nationally be clarified.**
- 18. That agencies be encouraged by key stakeholders including Local, State and Commonwealth governments to participate in quality program activities and that this be a condition of funding.**
- 19. That Commonwealth, State and Local governments use every opportunity to emphasise their commitment to delivery of quality services in the health and community services sector, including giving consideration to instituting national and state based awards for quality initiatives.**

Addressing Barriers

In summary the major barriers to the implementation of improvements in quality programs identified during the consultation were identified as being:

- the hierarchical nature of the sector and in particular the dominance of the acute hospital sector at the expense of the primary care system;
- the high staff turnover in the sector;
- lack of leadership both by management within services, and by government;
- imposition of inflexible and/or inappropriate standards or processes for their implementation, especially in the rural sector;
- competition between quality program providers;
- proliferation of standards, processes and reporting requirements;
- lack of resources at service level (particularly in smaller agencies) specifically for development of quality initiatives;
- lack of education around quality issues in the sector;
- lack of importance/status given to quality issues and those supporting them;
- 'blinkered approach' in pursuing one quality program approach at the expense of possibly more appropriate approaches;
- lack of easily accessible current information on quality issues;
- inadequate focus on consumers;
- inadequate marketing of quality program options;
- accreditation - both in 'interrupting' continuous quality improvement and in the time required;

- concerns around the quality of current quality programs, including whether standards and indicators are appropriate, processes adequate and appropriate and reviewers appropriate and properly trained.

## Rural and remote services

This section addresses rural and remote issues. Some of the information which is summarised here also appeared in earlier sections. However, rural and remote services have particular and specific needs that warrant additional coverage.

Rural/remote services shared the concerns of other services, however for them the situation appeared particularly pronounced. There was a sense that the issues for rural and remote services were not being sufficiently recognised by either quality program providers, or government.

There were particular issues for rural and remote service providers around the purpose of accreditation, appropriateness and flexibility of standards and review processes, peer review, and resourcing. There were also concerns about information provision and education and training.

### Purpose of accreditation

The importance of accreditation in providing recognition and credibility for services in small communities was raised particularly in the context of rural and remote communities. The rural and remote service providers also commented on the review process as either a tool for change management, or as a process for the inclusion of quality in service delivery. The following statement reflects the change management sentiment: *"It is well worth participating as it is a tool for driving change, it is slow and does need education, but it is well worth it"*.

Rural and remote services in particular had issues around isolation and high staff turnover. One manager of a rural/remote service commented: *"due to staff turn over of reviewer trained staff, this service lost a knowledge base, skills and support for the program amongst staff"*. Several comments by respondents from rural and remote services included the importance of the review process as contributing to bonding between staff: *"for me the sign of success was the bonding that happened among the staff as a result of the review"*. One suggestion for improvements to delivery of quality programs to rural and remote services was to provide *"more opportunities for staff bonding during the review process. Our organisation includes five hospitals covering 220 kilometres."*

### Peer review

As with other service providers, peer review was also important to rural and remote services. An appropriate but outside perspective broadened the options that services might consider and provided support and assistance. In discussing their preference for peer review the comment was made that: *"As a manager I felt that there was more rapport between us (the review team and manager). It makes a difference knowing they are in the same kind of business - it makes it more realistic. (One quality program) is predominantly designed to fit hospitals so you are constantly redefining the standards which means continually explaining community health"*. This reinforces not only the value of peer review, but also the importance of appropriate review teams and in fact the quality programs itself, to the service to be reviewed.

Although strongly supportive of the concept of peer review however, rural and remote service providers had particular difficulties regarding training of staff as reviewers, and their time release to undertake reviews. Concern around the cost of participation in quality programs was not only focussed on the direct fee for participation in the program, but also the overall cost in time and staff resources devoted to the process. In addition, in a peer review process, back-filling positions when reviewers were required to be absent from their own service for blocks of time while they reviewed others, was an issue for particularly smaller agencies, and those in rural and remote areas. One manager indicated that: *"Services can't afford to train staff as reviewers any more, the need to backfill their position whilst training and reviewing is too difficult"*.

Some of those consulted however, including reviewers, key stakeholders and service providers, expressed their belief that this cost was ameliorated by the experience reviewers brought back to their agencies, and that reviewing should be seen as a professional development activity. In smaller services however there was often a view that although this might be the case it was a luxury they could not afford.

#### Appropriateness of quality programs

The cost of quality programs was cited by a number of respondents as potentially reducing the appropriateness of the selection of the program: *"Cost is a consideration"*. One respondent from a rural/remote service commented that: *"In NSW huge financial pressures has created an environment where decisions are based on costs and not necessarily the appropriateness of the accreditation system"*. In an integrated agency in particular, a single program may be chosen when two parallel processes might be more appropriate. Alternatively the least costly program may be selected to comply with requirements, rather than the program most appropriate to the service.

In a number of cases there were comments from rural and remote respondents, that their service had for example used both QIC and one of the other review processes such as AQC, ISO or EQUIP. The latter was chosen by the larger organisation, but QIC was the preferred choice by those involved in community health service. Several of the respondents commented that this might be difficult in the future as the availability of funding for accreditation becomes more limited. *"They are prepared to pay for one, but it is a battle to get dollars for both, and that is going to be harder in the future. Everyone is budget conscious"*. Another respondent said, *"up till now our involvement was funded by the department; \$7000 - \$8000 is too much (for us)"*.

In addition to the problem of being integrated into a hospital setting and in some instances losing the ability to choose an appropriate review process for community health service, the make-up of review teams themselves was sometimes inappropriate to the service being reviewed. A common example of this was reviewers with only tertiary hospital experience being used to review small rural facilities.

#### Resourcing issues

Many of the respondents from rural and remote services mentioned costs as a barrier to quality assurance. This included not only the costs around provision of reviewers discussed above, but also the fee for participation in the program, and the increased costs of reviews in rural and remote areas, particularly when reviewers are bought in from other states. The cost of on site education was also raised.

The need to provide accommodation in a rural or remote location can significantly add to the cost of accreditation. One respondent stated *"we got caught; it cost us close to \$70,000 what with \$6,000 to join and \$24,000 per year and then all the accommodation, taxi's, food even where we had already provided it, for four teams cost us another \$40,000. The next time we only used one team with limited site visits but it was not nearly as good"*.

#### Information provision

Access to information is crucial to quality improvement, yet a number of stakeholders commented that information on quality issues was hard to obtain, particularly for rural and remote services. In addition, *"the discussion around quality programs is so esoteric...it's hard to translate it into my world"*. Concern was also expressed at the lack of understanding about accreditation generally and what it means for a service to be accredited. When referring to Aboriginal services, one of the respondents pointed out that there was little knowledge of the difference between continuous improvement and accreditation. The respondent noted that *"this is a real barrier, particularly as there is community resistance due to lack of understanding of the process."* It was suggested that *"it needs more involvement and*

*networking to involve community and clients and to create an understanding of the process, and a demonstration of the benefits.” It is unlikely that this is unique to Aboriginal services.*

#### Education and training

Education and training around the importance of continuous quality improvement in the health sector was seen by many of those interviewed as central to improving the quality of health service delivery. A number of the respondents in rural and remote services in particular, considered that quality assurance was not clearly understood by staff members at their organisation, and that this was exacerbated by their remote locations and the dearth of appropriate education for services in rural and remote locations. One respondent said, *“more education for staff on the process and quality assurance would have been useful. Education and access to trainers in remote areas is limited”*. Another respondent said, *“Ownership by staff is crucial therefore more staff education is required”*. *“Ongoing training to overcome loss of skills due to staff turnover”* was also mentioned as a particular difficulty in remote services.

#### Standards

The need for appropriateness and flexibility was particularly stressed by rural and remote service providers, and the key stakeholders involved with these services. *“There is no template ... There needs to be flexibility to respond to communities”*. There was a perception by many of those consulted that the standards used for rural and remote services have been set for or by, major teaching hospitals at a level that makes it impossible for rural services to attain. *“They just can’t do it and if the full standard was imposed the service would have to close.”* *“Size isn’t the only factor”*. *“The context for expectations in rural services needs to be taken into consideration .....Urban things do not necessarily relate to rural area”*.

*“You need to be careful where you set the bar”*. If the standards are set too high or implemented inflexibly, the service may have to close and the consumers (or residents in the case of services with residential units) will need to move. There are social issues to consider. Closure of services can result in community dislocation. *“But the community might be keen for the service to continue and at the standard at which it is being offered”*. The development and implementation process for the standards is therefore crucial in rural areas. Particularly for rural areas it was suggested that: *“Standards should be developed and based on managed risk”*.

Consultation must also be undertaken to ensure the standards and the process for their implementation is appropriate. *“Clinical standards especially, must not be developed in isolation of the industry that is delivering them.”* In rural areas *“this means (consultation) with GPs”*.

Concern was also expressed however that the development of standards and the flexibility around their implementation should not reduce standards in rural areas or give a perception of a lesser service. *“It is important to be able to say in the country that you receive an equivalent service to anywhere in the state”*.

# Appendices

# Appendix 1

## PROJECT REFERENCE GROUP

Ms Marcia Sleigh/Brendon Davidson	QIC Regional Manager (Tasmania)
Ms Julie McDonald/Ms Cheryl De Silwa	QIC Regional Manager (NSW)
Ms Judith Robson	QIC Regional Manager (Queensland)
Russell Renhard	QIC Regional Manager (Victoria)
Dr Greg Stewart	Director, Clinical Services, Central Sydney Area Health Service
Mr Gianfranco Spinoza	Project Manager, National Public Health Partnership
Dr Arthur Preston	Senior Research Fellow, Australian Centre in Strategic Management, Queensland University of Technology
Dr Roy Green	Associate Professor, Department of Management, University of Newcastle
Dr Joseph Ibrahim	Senior Lecturer, Department of Epidemiology and Preventative Health, Monash Medical School
Dr Colin Sharp	Associate Professor, Institute of Public Policy and Management, Flinders University
Professor Christopher Moorhouse	Chair in Rural Health and Community Nursing, University of Tasmania
Ms Jenny Wills	Australian Local Government Association representative
Ms Samantha Holmes	Assistant Director, Law Reform and Quality Section, Population Health Division, Department of Health and Aged Care
Ms Lynne Flemming	Executive Director, Public Health Association of Australia
Ms Meredith Carter/Prof Frank Fisher	Executive Director and Board Member, Health Issues Centre

### Provider and Reviewer Focus Group Discussion Schedule

#### Preamble

*QIC Ltd coordinates the Australian Health and Community Services Standards (formerly CHASP). QIC has received funding from the Commonwealth for a project that aims to strengthen QIC's capacity to promote and implement quality improvement in health and community services.*

**The project is in three components:**

- Review of quality improvement approaches in primary health and community services (including local public health and health promotion services)
- Development and implementation of a QIC standards monitoring and review cycle
- Development and implementation of a stakeholder participation process

The project workplan involves an extensive national consultation including focus groups of reviewers and service providers from the QIC Program.

We are interested in the following topics

- Experience or knowledge of quality review programs
- Comparisons of the various programs
- Enhancers for quality improvement programs
- Any perceived barriers to these enhancers
- Strategies for overcoming barriers to quality improvements programs
- Comments on standards

## **QIC PROJECT INTERVIEW PROFORMA**

- **Knowledge of other external quality review systems**

What can you tell us about the number and type of other external quality review programs in the health, welfare system, child services, aged or youth services?

Have you participated in any other external quality review programs outside of the health area?

- **Comparisons of the various programs**

How do the systems differ from each other?

How do you think the different quality review systems fit with the services being reviewed?

- **Impetus for particular program choice**

Why did you or others in the service select the particular external quality program used by your service?

- **Improvements**

What are your suggestions for streamlining or better coordination of the process?

What are the enhancers for a successful quality improvement program?

- **Barriers to these improvements**

What do you think are the barriers to improving the quality improvement processes?

How could these barriers be overcome?

- **Perceptions of the process**

What is your perception of the arduousness of the program?

To what extent do management and staff support quality improvement programs?

How much of the process is understood by management and staff of primary care and community services?

What do you as a provider or reviewer expect from quality improvement programs?

- **Comments on standards**

What did you think of the standards upon which the external quality review process was based?

How can quality standards contribute to better outcomes and processes for clients?

What issues arise from the implementation of the standards?

What factors should be taken into account in the development and implementation of standards?

### Stakeholder Interview Schedule

Preamble

*Quality Improvement Council (QIC) Ltd coordinates the Australian Health and Community Services Standards (formerly CHASP). QIC has received funding from the Commonwealth for a project that aims to strengthen QIC's capacity to promote and implement quality improvement in health and community services.*

**The project is in three components:**

- Review of quality improvement approaches in primary health and community services (including local public health and health promotion services)
- Development and implementation of a QIC standards monitoring and review cycle
- Development and implementation of a stakeholder participation process

The project workplan involves an extensive national consultation including focus groups of reviewers and service providers, and individual interviews of key stakeholders. This interview is part of the project. The information will only be used to inform the project.

General areas to be covered

- Quality standards and accreditation
- Comparisons of the various quality improvement and quality assurance programs
- Avenues for improvement
- Views on the development and review of QIC standards and operation
- Interest in participation in the ongoing operation/development of QIC
- Appropriate mechanisms for this

## INTERVIEW QUESTIONS FOR KEY STAKEHOLDERS

### **1. Background**

What is your experience with quality improvement and assurance programs in the health and community services sector?

### **2. Standards**

Do you consider that it is important to have quality standards in the health and community services sector?

What should be the process for their development?

### **3. Accreditation**

Is formal accreditation important?

What are the costs and benefits of complying with standards or participating in an accreditation process?

### **4. Comparisons between the various programs**

What comments would you make about current quality improvement approaches in the primary health and community services sectors?

How would you compare the various quality programs?

### **5. Expectations of quality programs**

What are your expectations of a quality review program in the health and community services sector?

To what extent are your expectations met?

### **6. Improvements**

How could quality programs be better implemented in the sector?

### **7. Barriers to these improvements**

What do you think are the barriers to these improvements?

### **8. Strategies for overcoming barriers**

How could these be overcome?

## **9. General opinion of the QIC program**

What is your opinion of the QIC program?

**The QIC program is interested in broadening its client base through the modules it offers. (A brief explanation may be required.)**

What program areas do you believe would benefit from the QIC program?  
If so, do you have any specific suggestions where approaches might be made?

## **10. QIC Standards Monitoring and Review Process**

Do you have a view about how QIC should monitor and review its Standards?

## **11. Stakeholder involvement**

**QIC is looking at broadening the involvement of key stakeholders in its operation. This could be on a variety of levels for example just being kept informed through a newsletter, being a member of advisory committees, to being a member of the QIC Board.**

What suggestions would you make for involving stakeholders (eg such as yourself, academics, professional associations, funder and consumer representatives) in QIC?

Would you or your organisation be interested in having a greater involvement in QIC?

**If yes inform interviewee that a short survey will be sent out as part of the project to canvass interest in more involvement in QIC.**