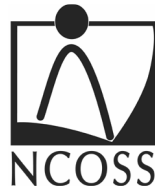


The NSW Association for Adolescent Health Inc.

Funded by NSW Health



P.O. Box 613, Strawberry Hills, NSW 2012
Phone: (02) 9699 1033 Fax: (02) 9699 3131
Email: eo@naah.org.au Web: www.naah.org.au
ABN: 411 2093 2447



Council of Social Service of New South Wales

66 Albion St, Surry Hills NSW
phone 02 9211 2599 fax 02 9281 1968
email info@ncoss.org.au web www.ncoss.org.au
abn 85001 797 137

Ms Margaret Banks
Head, Ambulatory Care
Australian Commission on Safety and Quality in
Health Care
Email: mail@safetyandquality.gov.au

30th March 2007

Dear Ms Banks

Joint submission regarding the implications of a *National Safety & Quality Accreditation Standards* on the community health & non-government organisation sectors

The NSW Association for Adolescent Health (NAAH) and the Council of Social Service of New South Wales (NCOSS) thank you for the opportunity to provide a submission during the consultation period discussing the implications of a *National Safety and Quality Accreditation Standards*.

These comments expand on the feedback NAAH and NCOSS provided to the consultation forum held 28th March 2007 (morning session). We sincerely ask you to consider the matters we have raised for, like you, we seek the enhancement of opportunities to promote the delivery of quality and safe health care services.

The NSW Association for Adolescent Health Inc¹ and NSW Youth Health Services

The NSW Association for Adolescent Health Inc. (NAAH) is the peak body committed to working with and advocating for the youth health sector² in NSW to promote the health and well being of young people aged 12-25 years. NAAH aims to assist the youth health sector to strengthen and maintain its ability to provide relevant and evidence-based health services to young people aged 12-25 years.

NAAH works closely with the State's fifteen youth health services and with the NSW Centre for the Advancement of Adolescent Health (CAAH). Most of NAAH's work focuses on providing youth health

¹ The NSW Association for Adolescent Health Inc.'s website: www.naah.org.au

² The Youth Health Sector includes any service/agency that works towards the betterment of the health and wellbeing of young people.

sector with support and training, government liaison and lobbying, policy and resource development, and community sector networking.

Youth health services are community-based health services which offer a diverse range of programs such as counselling, health promotion, medical / nursing clinics, alcohol and other drug services, outreach and drop in health services to young people aged 12-25 years. Some services are non-government organisations and others are strongly linked to Area Health Services. The primary target group for youth health services are young people identified as 'at-risk', disenfranchised, homeless or at-risk of homelessness and who are unlikely to access mainstream services. Some youth health services also work with young people and their families/ carers to support their health and well-being.

The Council of Social Service of New South Wales³

The Council of Social Service of NSW (NCOSS) is an independent non-government organisation and is the peak body for the non-government human services sector in NSW. NCOSS works with its members on behalf of disadvantaged people and communities towards achieving social justice in New South Wales. NCOSS membership is composed of community organisations and interested individuals. Affiliate members include local government councils, business organisations and Government agencies. Through current membership forums, NCOSS represents more than 7,000 community organisations and over 100,000 consumers and individuals.

The Community Health and Non-Government Sectors

NAAH and NCOSS are concerned that the Commission's call for submissions and participation in the consultation forums may not truly represent the needs of health care providers from the non-government and community health sectors. The Discussion Paper highlights implications for the acute medical care and diagnostic services involving patients and hospitals. It does not reflect the diversity of the health sector including community health which finds itself accountable to several different accreditation bodies such as the Australian Council on Healthcare Standards and Quality Management Services (QMS). Nor does the Discussion Paper mention the broad and extensive health non-government organization (NGO) sector which experiences varying levels of involvement in the accreditation process. Many NGOs, for example, have only recently commenced work on accreditation processes for their organisation and many organisations are yet to commence discussions about this issue. Yet the proposals in the Discussion Paper have major implications for NGO health service providers who provide everything from drug and alcohol (D&A) services through to sexual health education programs in the community. In short, although the Commission reiterates these standards will affect the NGO sector, this is not borne out in the Discussion Paper. There is a risk that the Commission has missed a valuable opportunity to have greater feedback and involvement from the community health and NGO sector as a result. Perhaps these issues are related to the lack of clarity as to the definition of 'health care provider'.

The community health and NGO sectors appreciate the need for accreditation and the development of standards but an ongoing issue is the lack of funds and adequate staffing levels available to conduct the appraisals/ reviews and then implement any recommendations from the process. All of these issues need to be considered in future debates and consultations about the future of a national safety and quality accreditation system if clients' health outcomes are indeed the focus behind any changes to the system.

Comments on Reforms proposed in Discussion paper

- **Register of accreditation bodies** – There is currently no core list or register of bodies with expertise in the task of accrediting health care providers. A register would, amongst other things, provide isolated community-based service providers and consumers with advice and greater access to information about accreditation, minimum standards and complaints' processes.

³ The website for the Council of Social Services New South Wales: www.ncoss.org.au

- **Standardise accreditation and standards language** – Consistent definitions of key accreditation and standard terms such as standard, benchmark, performance measure/ indicator is required. Differentiation will also need to be made between those standards and processes which are based on evidence (and thereby need to demonstrate adhering to such evidence).

In addition, a definition of 'health care providers' and/or 'health care settings' is required for consistency and to promote engagement with the whole process. In particular, as more and more health services are provided in decentralised settings such as the home or outreach services in the community, 'health care settings' needs to be defined. Perhaps also definitions about 'patients', 'clients', or 'consumers' is also required, acknowledging the language of different settings and the different relationships clients have with their various health care providers. For example, some consumers may also be involuntary and these differentiations require consideration before blanket standards are developed.

- **Training and competency testing of surveyors** – NAAH and NCOSS support the call to review the training and assessment requirements of surveyors across the health sector, and recommend that identified gaps be mapped e.g. noting if there is a lack of surveyors with experience in community-health settings, for example.
- **Data Linkages for Accreditation and Service Performance** – Data collected through accreditation can potentially serve policy-makers, funding-bodies, consumers, staff and service managers to measure a service's performance. However, such measurements should also capture contextual issues such as comparative funding levels, staffing levels and waiting lists/ community demand i.e. establishing WHY particular results are achieved through the accreditation process is equally as important as WHAT results are achieved through the accreditation process.
- **Registration of standard setting bodies** – There is currently no over-arching, consistent or formal link between standard setting bodies and the Commission appears to be in the best position to undertake this role, as an independent, national body. This will, however, be a long-term process, requiring consultation, the establishment of minimum requirements and monitoring for compliance. These issues will need to be considered in light of the Commission's funding timeframe and mandate.
- **Detailed mapping of standards** – If the Commission takes a lead role in 'registering' standard setting bodies and accreditation bodies, it appears valid to suggest that this activity could in turn require mapping all existing Australian health care safety and quality standards currently in place. It would be useful for organisations, like youth health services, which are accountable to more than one accreditation body (and subsequent sets of standards) to identify and to minimise the overlaps.

Some of this mapping has occurred in NSW across programs including health and non-health standards. This model could be applied nationally.

- **Identification of core safety and quality standards and performance indicators** - Establishing a core set of safety and quality areas is admirable but no doubt likely to be an arduous task accreditation and standard setting bodies have a variety of academic backgrounds, experiences and values. This area requires further consultation but the Commission could take a lead role in coordinating the initial debate.
- **Introduction of unannounced surveys** – NAAH and NCOSS recommend that this area requires further broad stakeholder consultation and negotiation because although there is agreement that quality improvement should be a continuous process, i.e. part of an organisation's core policy and procedures, the impact unannounced surveys can have on direct service provision and hence clients' access to health care needs to be considered. Unlike the other realms/ sectors where unannounced surveys are being used in Australia (namely food services, building compliance and

random speeding and breath-test checks), the nature of health care service provision is a complex and dynamic area and consumers must be afforded quality care.

Consent and confidentiality are important considerations. Vulnerable groups, in particular, (such as young people, the elderly, people experiencing homelessness, mental illness, disability and language barriers, to name a few) often already experience significant barriers to accessing health care. Research indicates that incidents such as breaches in confidentiality by a health practitioner reinforce negative experiences and promote feelings of mistrust for young people (CAAH 2002⁴). Consumers, whose first language is not English, already face the hurdle of having a second person (the interpreter) in the room as they negotiate their health care with their health care provider. In terms of the processes required, shall consumers now be required to sign consent forms about the possibility of being involved in an unannounced survey? The community health and NGO sectors are currently and will probably continue to face funding restrictions, limited staffing levels and waiting lists as they attempt to deal with consumers with chaotic life circumstances and complex health needs. Hence, there are the inherent impracticalities of surveyors arriving unannounced during crisis periods, staff meetings, and client sessions, placing further strain on already stretched services. There is the risk that unannounced surveys could add an additional barrier or disincentive for consumers wishing to access a health care setting. Unannounced surveys also have the potential, if not handled professionally or by suitably qualified professionals, to further distance service providers from actively engaging with quality assessments and accreditation processes.

- **Introduction of Tracer Method in external accreditation reviews** – The tracer method may be able to provide a consumer perspective but it is unclear how the client is chosen and what the benefits are to the client participating. There is also the concern that one client may not be able to reflect a service's whole operation. Furthermore, there is the risk that 'hard-to-reach' clients (e.g. clients with difficult life circumstances and complex health needs or clients from culturally and linguistically diverse backgrounds) will not be chosen for this process as their health needs or need for an interpreter will be too financially or time costly. From a quality improvement perspective perhaps this method may be optional, based on the organisation's clients group and service characteristics.

Thank you for providing NAAH and NCOSS with the opportunity to provide comment on the implications of a *National Safety and Quality Accreditation Standards*. We welcome the opportunity to discuss these matters further and to participate in future forums to address or further elaborate on these concerns.

Yours sincerely



Vanessa D'Souza
Executive Officer
NSW Association for Adolescent Health



Linda Frow
Acting Director
Council of Social Service of New South Wales

⁴ Centre for the Advancement of Adolescent Health NSW (2002) [Access to health care among NSW adolescents: Phase One Report](http://www.caah.chw.edu.au/resources/access_phase_2_report.pdf), CAAH. Online source: http://www.caah.chw.edu.au/resources/access_phase_2_report.pdf Date of access: 30.03.07.