

Project Brief No. CS.1

CONSUMER ROLES IN ACCREDITATION

FINAL REPORT to the
Royal Australian and New Zealand College of Radiologists

Submitted by

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Important Notice

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We would also like to extend our thanks to the Fellows of the College who reviewed the Draft Report and provided comments on it.

Our thanks are also extended to all the stakeholders who contributed their advice and perspectives on accreditation, and whose support for consumer participation will be important in ensuring a successful partnership with consumers in the accreditation activities of the College.

1 Executive Summary

This is the Final Report of the QUDI Project – CS.1 Consumer roles in Accreditation. The purpose of this project was to review and recommend consumer role(s) (of consumer advocates) in the development and implementation of the practice accreditation program.

The Royal Australian and New Zealand College of Radiologists contracted Australia's Health P/L to conduct a time-limited investigation of current and emerging roles of consumers in accreditation programs, both within Australia and overseas; consult with key stakeholder groups to understand their perspectives on consumer participation and the roles consumers might take; and develop and recommend a generic procedure for engaging consumers in accreditation activities conducted by the College.

The CS.1 Project had four stages distributed over a total of 12 weeks. Formal execution of the Contract was completed on 20 March 2005, and the Project commenced on 21 March 2005. Data collection and interpretation concluded on 18 May 2005. This short time period necessitated a highly structured approach to develop a generic procedure for both engaging consumers in RANZCR activities as well as documenting the rationale for consumer representation to members of the College.

It used a mixed methods approach, drawing on a systematic literature review; consultation with key stakeholder organisations directly and via a brief survey; and our understanding of consumer issues, to inform the development of a generic procedure for engaging consumers in the accreditation activities of the College. The methodology included the development of a Detailed Work plan, verbal progress reports throughout the project; an Interim Progress Report; the development and dissemination of a Key Issues Paper to selected stakeholders for comment; a Draft Final Report which included a generic procedure for engaging consumers in the accreditation activities of the College, and which was distributed to a number of the College Fellows for review; and culminates in this Final Report which includes the recommendations from the reviewers.

Literature review

Our review of the literature has confirmed there is a developing community expectation of involvement in accreditation, which reflects one consequence of the promotion of accreditation as a strategy to encourage consumer confidence in health services and providers. Consumer organisations consider that it is essential that consumers are participants in both their own health care and at a system wide level in improving the quality and accountability of services to the communities and governments which fund them.

Consumers' expectation of involvement in accreditation varies across the consumer sphere. Some expect to be interviewed as part of the assessment process, some want inclusion as part of the survey team; some just want transparency of the process and to be accurately informed of the outcomes of accreditation. Some want to be involved at all levels including the governance structures of any accreditation system, as well as in any remediation processes where accreditation indicates less than adequate compliance with standards

There is a variable level of consumer involvement in the standards setting or accreditation processes. In some countries, Australia included, accreditation agency standards are developed in partnership with members of the public through their participation in workshops

and consultation processes; consumers can also be part of the review team that visits the services undertaking accreditation. In others, consumer participation is passive – limited to provision of commentary on website publication of draft standards.

There is however evidence of growing professional awareness of the roles available to consumers in accreditation. These roles extend from consumer participation in the governance of accreditation agencies; to involvement in the development and review of standards used in accreditation; and to participation in practice review and assessment as members of accreditation survey or review teams. They indicate that consumer involvement in the broader health sector is recognised as a significant aspect of quality assurance and quality improvement.

Several of the Specialist Medical Colleges have explicit roles for consumers in the development of accreditation standards; consumers are engaged as surveyors in mental health services in Australia and New Zealand, and in hospital accreditation by the Australian Council of Healthcare Standards and the Quality Improvement Council. Other examples of explicit consumer involvement in either the development of accreditation standards or as assessors are found in the Private Health Industry Quality and Safety Committee; RACGP National Expert Committee on Standards for General Practices; The National Pathology Accreditation Advisory Council; The National Association of Testing Authorities; and the National Quality Management Committee of BreastScreen Australia.

There is some literature which considers the consequences of not involving consumers – especially diminishing confidence and trust where consumers are not involved in significant decisions in the health care system. Some literature also identifies benefits flowing from consumer participation, especially in relation to governance and accountability, innovative quality improvement which reflect consumer concerns and priorities, and community education.

Stakeholder consultations

Our research has demonstrated that there are barriers to effective consumer participation – including what consumers describe as the persistence of paternalism as well as health professionals' intransigence in the face of changing community expectations. The barriers are not just attitudinal: there are also capacity barriers for consumer participation including financial, temporal, and educational technical and health.

There is scope for improving consumer knowledge and information about the purpose of accreditation, since accreditation is misperceived by some to be an indicator of the safety and quality of care, or act as a guarantee or endorsement of the quality of care provided by the accredited organisation. There is also scope for improving professionals' understanding of the capacity and appropriateness of engaging consumers in accreditation activities.

Survey responses

Survey responses in relation to involvement in diagnostic imaging accreditation confirm these points. Consumers clearly wanted to participate in the governance and oversight of accreditation and standard setting, and as members of survey teams - roles with which most specialists agreed and were supportive of. Staff of the peak professional organisations however, were generally not supportive of these roles, however it is our view that this is partly due to lack of familiarity with the willingness of consumers to be engaged in a meaningful way, and the capacity of consumer representatives from peak consumer healthcare organisations to provide appropriate input to these activities. This Report suggests there is a need to develop an awareness strategy which addresses this gap in knowledge.

The majority of survey respondents agreed that in order to effectively engage consumers, there needs to be consideration of roles and expectations, recruitment, training, support, resource and remuneration issues. These were all regarded as potentially barriers as much as enablers for consumer participation.

Generic procedure

The generic procedure for engagement of consumers in the College's accreditation activities follows the continuous quality improvement model using a 'Plan-Do-Study-Act' approach which is commonly used in health settings in Australia and overseas in bringing about organisational change in an effective, acceptable way.

2 Introduction

This is the Final Report of the QUDI Project – CS.1 Consumer roles in Accreditation. The purpose of this project was to review and recommend consumer role(s) (of consumer advocates) in the development and implementation of the practice accreditation program.

The Royal Australian and New Zealand College of Radiologists contracted Australia's Health P/L to conduct a time-limited investigation of current and emerging roles of consumers in accreditation programs, both within Australia and overseas; consult with key stakeholder groups to understand their perspectives on consumer participation and the roles consumers might take; and develop and recommend a generic procedure for engaging consumers in accreditation activities conducted by the College.

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The four stages were:

Stage One: March 21- March 24

Project initiation; development and submission of detailed work plan, timelines and budget (Attached Appendix A)

Stage Two: March 29 – April 29

Develop literature search strategy; identify key documents and commence review. Identify key informants to receive the Brief Survey and provide any additional discussion of issues emerging from literature and document review.

Develop Brief survey schedule taking into account issues emerging from discussions with key stakeholder organisations identified in the Brief, and the concurrent literature review; disseminate survey to key informants and follow up as necessary, and commence collation and analysis of data. (Attached Appendix B)

Stage Three: May 2 – May 27

Summarise main findings from literature review and survey in a Key Issues Paper for distribution to selected key stakeholders for comment. (Appendix C). These stakeholders were identified in consultation with the QUDI Project Manager. Their comments and feedback will be incorporated in the Final Report of this Project. Develop a generic procedure and rationale for engaging consumers in College activities for inclusion in the Draft Final Report. (Refer Section 6 of this Draft Final Report).

Stage Four: May 23 – June 10

Incorporate feedback from Stage Three activities into the Final Report, which will be presented for either hard copy or website publication. Feedback from the College was received on 14 June and has been incorporated into this Final Report.

2.1 Background to this Project

The Quality Use of Diagnostic Imaging [QUDI] Program has as its terms of reference, the identification, development, implementation and evaluation of initiatives aimed at improving the quality use of diagnostic imaging services; the employment of evidence-based methodology wherever possible; the recognition of the role of consumers, diagnostic imaging providers and referring practitioners in attaining quality use and involvement of them through collaboration, consultation, partnership and multidisciplinary activities; and adoption of a system-based approach with application to multiple sites and at multiple levels across the health system¹.

The objectives of the QUDI Program are based on nine dimensions – effective, appropriate, efficient, responsive, accessible, safe, continuous, capable and sustainable – each of which is likely to resonate with the community in relation to its expectations for quality diagnostic imaging services².

The QUDI Program has a number of sub-programs, of which the first relates to the current project: Quality Consumer Services – with the objective of developing and improving consumer focused, accessible and coordinated services that promote informed choice and meet consumer needs³. The four sub-programs provide the context for a strategic and incremental approach to the QUDI objectives.

RANZCR commenced a voluntary accreditation scheme in May 2004, and this will provide the basis for development of a mandatory accreditation scheme for radiology practices under the Radiology Quality and Outlays Memorandum of Understanding, 2003-2008. The mandatory accreditation has an operational date of November 2005 (with appropriate transitional arrangements)⁴.

It is within this context that the current project has been commissioned by RANZCR.

Consumer involvement in the broader health sector is an area of contemporary focus and a recurring question is where and how to engage consumers in a meaningful way at all levels of planning, implementation and evaluation of the health system. Accreditation is increasingly recognised as an important strategy for improving the quality and safety of the health system, but a preliminary scan of published literature suggests there is at this time, limited systematic engagement of health care consumers in quality improvement strategies. There is literature on improving consumer feedback, and the need for greater public accountability through accreditation processes.

There is a practical start in the engagement of consumers as auditors (for example in mental health services in Australia under the National Mental Health Strategy, and in NZ, where this is a legislative requirement, and consumer auditors are trained to relevant ISO standards; the engagement of consumers as surveyors by the Australian Council of Healthcare Standards and the Quality Improvement Council). This engagement has triggered discussion about the preparation, competence and responsibilities of consumers who are to be participants in accreditation activities. Guidance on how this might best be achieved is timely.

The principles which underpin both the QUDI terms of reference and the Program objectives are shared with a number of related health care policies and strategies, including the Quality

¹ Request For Proposals CS.1 Page 8

² *Op. cit.* Page 9

³ *Op. cit.* Page 10

⁴ *Op. cit.* Page 7

Use of Medicines and the Quality Use of Pathology strategies⁵. These principles recognise the relationship that exists between consumers and providers, the need for best practice, and the requirement for a strong, active role for consumers at all levels of the health sector⁶. A number of recent Australian reports also emphasise these principles in discussing consumer participation in accreditation – for example, the Consumer Focus Collaboration (2001), the National Expert Advisory Group on Safety and Quality in Australian Health Care (1999), and the Australian Council for Safety and Quality in Health Care.

⁵ Request For Proposals CS.1 Page 8

⁶ *Op .cit.* Page 13

3 Methodology

The approach to data collection and interpretation relied on a mixed methods approach which draws on a range of data sources, enabling triangulation, verification and validation of data. The particular mix of methods identified as appropriate for this project included:

1. Review of recent published professional and consumer literature and document sources such as health policy and program initiatives; reports from specialist Colleges here and overseas on initiatives supporting consumer engagement in accreditation activities; identified standards, guidelines and practice policies; consumer organisations' publications relating to consumer participation in health system activities and accreditation in particular.
2. Brief survey of key diagnostic imaging stakeholder organisations, and
3. Follow up consultations with selected key informants to clarify issues raised

This combination which recognises the Project timeframes and budget allocation, was selected to appropriately engage key stakeholders in reporting their perceptions and expectations of consumer engagement in accreditation *per se*, and in accreditation activities conducted by the RANZCR in particular. It is a combination that facilitates richness to the scope and depth of data that can be accessed in a short time frame, and provides composite data which can support the interpretations based on it.

The information provided by this mechanism is supported by the understandings the Consultants have based on their previous experience of engagement with consumer organisations and their members, and particularly their knowledge of consumer perspectives and expectations for involvement in accreditation activities.

3.1 Literature and document Review

A computer-assisted search was undertaken of published professional and consumer literature and other document sources such as health policy and program initiatives and reports on initiatives supporting consumer engagement in accreditation activities. The electronic databases used included PubMed, Sociological Abstracts, Medline Advanced (APAI), Aust Health, Embase, and Cochrane Database of Systematic Reviews.

Key search terms included: consumer(s); patient(s); participation; accreditation; evaluation; quality assurance; quality improvement; best practice.

In addition website searches were conducted of the Specialist Medical Colleges in Australia to identify standards, guidelines and practice policies for consumer engagement; and of peak Australian and New Zealand Consumer Organisations for publications and position statements relating to consumer participation in health system activities and accreditation in particular.

Website searches of Australian and overseas organisations such as professional colleges and bodies included: Australian General Practice Accreditation Limited; the Specialist Medical Colleges, including RANZCR, Royal Australian College of General Practitioners, Royal Australian & New Zealand College of Obstetricians and Gynaecologists, RANCP,

RANZCP, Australian College of Rural and Remote Medicine; The Australian Diagnostic Imaging Association; Cardiac Society of Australia and New Zealand; Australian and New Zealand Society of Vascular Surgery; Australian Divisions of General Practice; Australian Council of Safety and Quality in Health Care; Australian Council on Healthcare Standards; Quality Improvement Council; Department of Health and Ageing; the National Health and Medical Research Council; the National Institutes of Health; National Health Care Quality Forum; Joint Commission for the Accreditation of Healthcare Organizations; and the National Guidelines Clearinghouse.

Website searches of the peak health consumer organisations in Australia and New Zealand consumer advocacy organisations included: Consumers' Health Forum; Health Issues Centre; Healthcare Consumers' Association of ACT; HealthCare Consumers of WA; National Resource Centre for Consumer Participation in Health; Women's' Health Action Trust; The Consumers' Institute.

The search particularly focused on identification of key consumer roles in accreditation and successful models of consumer engagement, philosophies on consumer involvement in accreditation, consumer and practitioner expectations and attitudes to consumer engagement, together with any consequential issues (such as barriers and enablers to consumer participation, legal, risk management, and financial issues which impact on consumer participation) which were included in that literature.

The search strategy initially identified 112 items, which were retrieved and scanned for their applicability to the project tasks, including whether they might suggest conceptual or theoretical models for consumer engagement. Literature which was not related to health system or service accreditation, or which did not focus on consumer participation was excluded.

This resulted in 74 items which were directly related to the target items – consumer roles in accreditation; models of consumer engagement in health professional or service accreditation; philosophies on consumer involvement in accreditation; consumer and provider expectations and attitudes to consumer engagement; barriers and enablers to consumer participation. All reports supported to at least some degree, the merits and benefits of consumer engagement and participation in accreditation activities. Key barriers and enablers for consumer participation expressed in the available published materials were identified and reported in the review.

The Literature review is reported in Section 4 of this Report.

3.2 Brief survey schedule

The time limits of this Project required a convenient and effective mechanism to elicit key stakeholder organisational perspectives on consumer engagement in accreditation programs. The strategy selected to achieve this was a brief survey which was emailed to selected peak organisations inviting a rapid response to a series of questions.

Content for the brief survey was based on themes identified in the literature reviewed for this project. These themes reflected the range of dimensions considered important to understanding the processes, appropriateness, impact, and outcomes of consumer engagement models in relation to College accreditation activities. In translating these themes into survey items, the consultants' took into account their judgement of the appropriateness of items based on their previous experiences in surveying consumer and professional

organisations, the expectation of competing priorities within peak organisations particularly when invited to respond in a short time frame, and the need to facilitate a rapid response to survey items. It was structured to allow participants to complete it in a minimum of time and at little cost to either the project or the participants.

The survey was intended to elicit information on organisational perspectives on consumer participation in diagnostic imaging accreditation activities, and the questions were clustered around broad themes, including understanding of roles for consumers in accreditation activities; barrier and enablers for consumer engagement and participation; principles for engaging consumers; resourcing requirements for consumer engagement and participation; and accountability.

The survey completion required simple Yes/No responses to the clustered questions, and permitted inclusion of additional explanatory comments as respondents wished. Survey respondents were also invited to identify any organisational documentation they considered relevant to the aims and objectives for this project.

Key stakeholder organisations were identified in consultation with the client. The Brief Survey is attached in Appendix B. A summary of the survey responses is reported in Section 5 of this Report. The distribution list for the survey is in Appendix E.

In addition, a small number of key informants were contacted by telephone to gain their views relating to consumer engagement in accreditation programs, identify current initiatives and models for consumer roles in accreditation, and views on the effectiveness and appropriateness of these engagement strategies.

Together with the literature review, survey responses have enabled the identification of current initiatives and models for consumer roles in accreditation, and views on the effectiveness and appropriateness of these engagement strategies.

3.3 Analysis

The combination of methods generated a number of data sets capable of triangulation, and linked by common identifiers such as stakeholder grouping and experience in consumer engagement.

All data collected was qualitative and was accordingly subjected to content and thematic analysis.

4 Literature review

The focus of the review for this time-limited project was on the recent published professional and consumer literature (including any unpublished reports, policy documents and position statements that could be identified by researchers using the agreed broad search strategy including website searches, the College including advice from the TRG, and the advice of stakeholders contacted for this project). A description of the search strategy, the scope of the search, the databases and other data identified, the search terms together with the inclusion and exclusion criteria used can be found in Section 3 of this Report.

It was outside the scope of this project to conduct a systematic and critical review of the quality of the literature, but rather to conduct a search strategy that was likely to capture all public domain reports and publications from the last 10 years. It was assumed that all reporting on consumer engagement – favourable or unfavourable – would be captured by this approach. Those which were accessible – in either electronic or hard copy form - in the time available for this project were retrieved and reviewed.

The literature identified and reviewed for this project was expected to augment the data obtained, and conclusions drawn from the other strategies used in this project – stakeholder comments and responses to the brief survey and interviews. The search and retrieval strategy was considered broad enough to enable any published positive or negative consequences of consumer participation in accreditation to be discovered, but was not intended to critique the strengths and weaknesses of the extant work. A critique of the literature for rigor, thoroughness or quality was outside the scope of this review; such a critique may be a useful focus of a separate future project.

4.1 Accreditation

Accreditation is the process whereby a service is furnished with a credential by an external body which testifies that the service meets predetermined standards¹. It is a review against explicit standards².

Credentialling on the other hand, is the process of confirming the formal qualifications of a person⁷ and the process by which [individual] physicians are determined ... to be competent and are permitted to perform procedures.⁸ It is a key component of professional governance where the standards for practice set by the members of a profession establish the minimum requirements for entry, continuing practice, endorsement and recognition of the individual practitioner.

At an international level, organisations that provide accreditation, both in health care and other sectors, list numerous benefits of the process. Many of these benefits are related to the view that accreditation offers an objective indication that an organisation, facility or service operates to a consistently high standard. Within the healthcare industry, accreditation is promoted on the basis of encouraging consumer confidence^{3 4 5 6} lending credibility to

7 Australian Council for Safety and Quality in Healthcare (2001). Credentialling.

8 RANZCR Guidelines for Credentialling for Interventional Radiology <http://www.ranzcr.edu.au/qualityprograms/accreditation/credentialling.cfm> accessed 27 June 2005

performance reports; helping organisations attract a high standard of staff^{3 4 5} and increasing opportunities to gain funding.

In Australia, one of the major accreditation agencies – the Australian Council on Healthcare Standards [ACHS] - describes accreditation as:

“...a recognised signal to consumers and funders that the service has been judged by people who understand the nature of the service to have incorporated the principles of good practice stated in the standards into their everyday work practice and that they are continually looking to improve the care and service they provide for their patients / clients”⁷.

Accreditation processes are generally centred on an internal assessment conducted by the organisation undergoing accreditation in conjunction with an independent peer-based survey team. The internal assessment and the independent review are generally conducted every few years. The assessment criteria or guidelines used by accreditation agencies are based on standards for continuous quality improvement or a framework for quality management, depending on the type of accreditation being sought. Increasingly, accreditation agencies are aiming to use this process to stimulate a cycle of continuous quality improvement rather than having the focus of accreditation being a type of summative examination conducted every few years.

In the early to mid 1990s, many concerns were raised about accreditation processes – the main criticism was that they generally focused too much on structures and processes and not enough on outcomes for consumers of the services. For example, review processes gave great attention to the safety of buildings, policies, procedures and the establishment of committees, but traditionally gave less emphasis to systems for measuring the safety or effectiveness of the care provided. This is changing with the changes in the broader directions of health care. Part of this change has been the growing recognition that consumers can play a crucial role in effective accreditation.

There is literature which generally suggests benefits accrue to organisations which aaccreditation. While it clearly requires considerable effort on the part of the organisation seeking it, accredited status confers benefits to the organisation itself, its members and those accessing its services.

At the most obvious level, accreditation can be viewed as explicit demonstration to external stakeholders of the capacity of an organisation to pursue the values and adaptable work practices inferred in the continuous quality improvement approach. At another level, accreditation can be valued by staff as an activity which prompts team development, self-reflection, stimulation and consultation. These same attributes – continuous quality improvement values and responsive adaptable work practices are regarded as both key aspects in managing change within organisations and as indicators of the sustainability of the organisation⁸.

External benefits include the recognition given to accreditation by insurers and other third parties^{3 4 6}, and by referring professionals. Potential internal benefits to healthcare organisations for attaining accreditation include an increase in staff morale and teamwork through involvement in the accreditation process^{3 4 6} while enhancing staff education and providing professional consultation^{3 4 6} which stimulates quality improvement within the organisation. For example, healthcare organisations improve their compliance with standards when these are made explicit⁹. Accreditation providers promote ongoing benefits after achieving accreditation by continuing to support the organisation through providing information and education resources^{4 6 10}. Accreditation is also believed to enhance an organisation’s system of risk management.

The literature suggests that accreditation is regarded as a difficult process to evaluate for a number of reasons:

- the endpoints of accreditation are hard to define and vary according to expectations of users and observers
- individual programs vary around a common model
- accreditation is not a single process but a number of activities that interact to produce organisational change
- few countries offer a background in which case-control studies of accreditation can be satisfactorily performed without contaminating effects from other factors.

Despite these issues, there is consensus that accreditation processes and standards development have played an important role in improving safety and quality in the Australian health care system¹¹.

Accreditation is not an end in itself; rather it is a means to achieve accountability and quality improvement in both management and service delivery. There is already a developing literature on the factors which help or hinder the progress of quality improvement, and a growing consensus that organisational characteristics like leadership, direction, organisational culture, training, resources, and practical support are all important^{12 13 14}.

Ultimately the aim of accreditation is to improve the quality of healthcare^{4 6 9 10}. The significance to consumers of accreditation partly arises from one of its effects in encouraging consumer confidence^{3 4 5 6}. Conversely, lack of patient involvement in significant decisions in the health care system - leads to diminishing confidence and trust¹⁵.

Accreditation bodies are accountable to the consumers who receive services from accredited organisations; they are accountable to the purchasers who typically are guided by accreditation in their purchasing decisions; they are also accountable to the provider organisations to assure that a high quality professional accreditation is in place. However, first and foremost, the accreditation body is accountable to the public at-large for rendering professional judgments for the protection of the public. Thus, in the broadest sense, the accrediting body acts in the public interest to set standards of practice in a field, to evaluate conformance to those standards by organisations in the field, and to communicate that information to interested parties¹⁶.

4.2 Consumers and accreditation

The participation of consumers both in their own care and at a system wide level is now being recognised as essential in improving the quality and accountability of services to the communities and governments which fund them. A growing number of governments and health care providers are actively seeking the views of consumers about health policy, planning, service delivery and evaluation, arguing that a major benefit of involving consumers is the potential for improved quality of care.

The focus of quality in health care is increasingly recognising the assessment of quality in terms of the experience of those who receive the service. This shift can be seen for example in the engagement of consumers in partnership models in treatment and care; as members of strategic planning and resource prioritising groups within services; in corporate and clinical governance activities; in quality improvement initiatives; regulatory and access control mechanisms; and in accreditation and review programs.

Consumers see health services from a different perspective than the people who provide the services. That perspective is one of a person using and receiving services - experiences which can be invaluable in bringing an extra dimension to traditional ways of assessing quality.

A decade ago, Consumers' Health Forum (the national peak body representing more than 120 health consumer organisations) noted:

*"Increasingly consumers judge quality not only on the competence and effectiveness of the clinical treatment provided (and that is very important) but also on the way in which they are cared for within the health care system. For consumers, quality includes good communication with professionals, the provision of good information about services, professionals and treatments and having care which is coordinated and holistic. It also involves treating those needing health care with dignity and respect, including involving them in decisions about their treatments"*¹⁷.

The different perspective of consumers usually means that the questions they ask and the suggestions they tender will broaden the issues covered in the review process. While they are, of course, concerned with the technical aspects of clinical care, they are also concerned about other aspects of care which have not traditionally been considered as part of quality assurance processes or which may be given less of a focus by some health professionals. They include issues about the coordination and integration of care, communication, access to treatment, provision of information, and respect for consumer rights.

The development of meaningful consumer participation is regarded by some as an essential element of best practice. In 2001, the Australian Council for Safety and Quality in Health Care [ACS&QHC] - which has a broad focus in safety and quality in Australian health care - published its National Action Plan which identified 4 priority areas for a safer, more accountable Australian healthcare system: Better use of data/information to support safer care; Strengthened mechanisms to ensure safer clinical and organisational environment; Active promotion of opportunities for consumer feedback and participation; and the redesign of care systems and processes to promote strong culture of reliability and safety. This is consistent with the view articulated in the WHO (1986) Ottawa Charter¹⁸ - that community involvement in determining health priorities and resource allocation is *essential* to improving the health of people and the health system.

The ACS&QHC itself has consumer members of the Council¹⁹; consumers participate in all its working groups and taskforces; consumers participate in various *ad hoc* Council groups such as tender evaluation panels, selection panels for programs like the Safety Innovations in Practice (SIIP) program, standards development committees and project steering groups.

The ACS&QHC Working Group on Accreditation²⁰ has now identified a number of principles that should underpin the national approach to accreditation systems in health. These principles include:

- effective consumer engagement throughout the accreditation system, including engagement in the governance arrangements of these systems;
- active contribution to the development of accreditation standards, and active involvement in the assessment of services against those standards;
- consultation with consumers regarding what and how they want the outcomes of accreditation to be reported.
- Consumer engagement must include patients, community members, carers, patient advocates and consumer organisations.

These principles are steadily permeating accreditation agencies – some of which require an organisational commitment to consumer and community participation as a requirement of their accreditation programs (for example, the ACHS Evaluation and Quality Improvement Program [EQulP]²¹ which requires consumer participation in care delivery, planning and quality improvement through to the Practice Incentives Program [PIP] where accreditation, including consumer feedback is required for entry²²). ACHS also has consumer representation at the Board level.

This 'reach' into the consumer perspective has not impacted on some consumers, and this may be related to the extent to which the reach is operationalised as well as the targets for the activities. There is a broad range of consumer views about accreditation, which reflects the degree of familiarity with accreditation principles and processes, and involvement in a representative capacity. For example, while some consumers indicate that information sourced from accreditation processes is of real value in their search for information about the safety and quality of care provided to them²³, others report a view that accreditation provides an indicator of the safety and quality of care. To these consumers, accreditation may be seen as an endorsement or guarantee that the services provided will be safe and of a high quality, and that adverse events will not occur. This is really a misunderstanding of the purpose and outcomes of accreditation.

Such a consumer misunderstanding is not surprising given the developing state of engagement in accreditation processes, and highlights an area for future development. Better informed and engaged consumers recognise that accreditation does not endorse or guarantee quality of care, or prevent adverse events or outcomes in health services; rather that accreditation signifies that an organisation has achieved compliance with specific standards, thereby improving its capability to prevent, manage and learn from health care safety and quality problems.

There are many ways in which consumers can be involved in accreditation processes, including developing the standards for accreditation; involvement in the governance processes of an accreditation agency; working on a quality improvement committee within a health service that is to be accredited; providing feedback to a health service and asking that this feedback be provided to the quality improvement committee or other committee which is charged with overseeing the service's accreditation process; being involved in consumer and community consultations which occur when the accreditation review is happening at a health service; or becoming a consumer surveyor or reviewer for an accreditation agency²⁴. The latter recognises consumer experience and knowledge as complementary to that provided by professionals in the evaluation of service quality.

Increasing effective participation by consumers in accreditation processes has the potential to bring about service-wide improvements. Consumers will bring a different perspective to the review, asking different questions and focusing on issues which may not have been raised before. It has the potential to increase the consumer focus of quality improvement activities and improve the content of accreditation feedback to services about consumer aspects of service quality. It should also encourage services being accredited to increase the extent of consumer participation in all of their quality improvement activities.

4.3 Consumer expectation of involvement in accreditation

Consumers' expectation of their involvement in accreditation activities is reported to vary across the consumer sphere. Some expect to be interviewed as part of the assessment process; some just want transparency of the process and to be accurately informed of the outcomes of accreditation; some want to be included as members of the survey team; some

suggest that where accreditation assessment indicates remediation is required to achieve the standard being assessed, consumers should be engaged in that process.

Generally speaking, 'ordinary members of the public' who are not part of consumer groups, prefer time-limited methods of participation, such as acting as respondents to requests for feedback or completion of satisfaction surveys or providing 'one off involvement in focus group or planning fora'²⁵. This is a relatively low level of participation, and may reflect these community members' dislocation from organised consumer advocacy and support groups, as well as lack of confidence, preparation and support for taking a more active role in their health services.

On the other hand, members of consumer organisations are 'committed to staying the distance', they wanted to increase the consumer 'voice' - especially for disadvantaged groups - and they want to make positive changes for other consumers²⁶. These consumer representatives are more likely to be involved at all levels including the governance structures of any accreditation system and membership of accreditation assessment teams. These consumers bring an organisational perspective to the process: they are usually trained in consumer representation, supported in this role by their respective networks, and are accountable back to their organisations.

Empirical evidence about the benefits of involving consumers in health services is starting to emerge^{27 28 29 25} - evidence which indicates that:

- Active consumer participation leads to more accessible and effective health services.
- Effective consumer participation in quality improvement and service development activities in health services is achieved through the adoption of a range of methods.
- Effective consumer participation uses methods that facilitate participation by those traditionally marginalised by mainstream health services.

In relation to accreditation, there is recognition that the process of development of standards must demonstrate clear and direct accountability to all stakeholders, including through inclusion of consumers on the standard-setting body³⁰. This is a change from just a few years earlier when, in their review of accreditation systems, Skok *et al* (2000) reported that:

"few of the accreditation systems [in Australia] provided 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".

These authors concluded that in general, accreditation agencies could be improved by requiring the organisations they accredit to involve consumers and consumer groups more in their service and in their continuous quality improvement processes, as well as by having more contact with consumers during the review process.

4.4 Consumers and development of accreditation standards

Standards are used to define the conditions for quality and are an essential component of an industry-wide quality improvement system. The development of appropriate standards is integral to the accreditation process, providing a benchmark against which service quality can be measured. The literature describes a standard as the minimum performance expectations, processes or structures that should be in place to ensure safe, high-quality services^{11 4}.

Standards can measure structure, process and outcomes. 'Structure' can be defined as the physical and organisational characteristics of an organisation (e.g. staff, equipment); 'process' as what is done in caring for the consumer (what the provider does, including the sequence of care delivery and the interactions that occur between the consumer and the health care provider); and 'outcome' as what is achieved in terms of improvement in health, attitudes, behaviour or knowledge³¹.

The literature reviewed for this Project indicates that there is a variable level of consumer involvement in the development of accreditation standards. This is despite many standards having a strong focus on the continuum of care, on the importance of providing high-quality, safe and effective care, and on providing information to patients about their treatment options³².

In Australia and overseas, the development of accreditation standards follows a number of principles which reflect the imperative to engage consumers in the process as well as orient the standards to encompass a consumer focus. For example, a set of international principles for the development of standards were developed by the International Society for Quality in Accreditation [ISQuA] as part of its Agenda for Leadership in Programs for Healthcare Accreditation³³. These were revised in March 2004 to encompass a broader range of health services standards accreditation³⁴.

The ISQuA Principles provide a generic guide to the development of health care standards for accreditation and emphasise that standards should be planned, formulated and evaluated through a defined, evidence-based process that involves professional, provider and consumer groups; and importantly, emphasises the patient/client focus in the scope of the standards.

In England, Wales and Scotland^{35 36} standards are developed in partnership with members of the public through their participation in workshops and consultation processes. (In Scotland, consumers can also be part of the review team that visits the services to undertaking accreditation³⁷). In the UK, standards development is co-ordinated at a national government level, with responsibility for implementing and measuring compliance against standards devolved to regions within the National Health Service [NHS] with strong input from the clinicians, other health professionals and consumers to help ensure that they are relevant to health professionals and patients³⁸. For example the QIS, an independent Special Health Board with responsibility for the development of cancer standards in Scotland, uses a process it describes as 'highly transparent' due to the involvement of health professionals, cancer services, research bodies, cancer organisations and consumers.

It is more difficult to ascertain the extent of systematic consumer participation in the development of accreditation standards in North America, although consumer involvement in the standards development and revision processes is explicitly required in the ISQuA'S International Principles for Healthcare Standards 2004, Second Edition. It is clear that a number of standards development groups (e.g. the American Cancer Society) have strong representation by clinicians³⁹ but consumer participation is less clear. While consumers are represented on the boards of Joint Commission on Accreditation of Healthcare Organisations (JCHAO) in the USA; and the Canadian Council on Health Services Accreditation (CCHSA); the websites of these organisations do not currently explicate the role for consumers in standard setting.

The American College of Surgeons focuses its activity on supporting and educating consumers about surgical issues through its public education program. This program provides information to consumers on how to assess a surgeon's credentials, on questions consumers should ask before providing consent to an operation, and producing procedure-

specific information resources⁴⁰. Involvement of consumers in the accreditation activities of the College is unclear.

In Australia there are a number of examples of where consumers are explicitly involved in the development of accreditation standards. For example, the Private Health Industry Quality and Safety Committee [PHIQS] has consumer membership⁴¹; the RACGP National Expert Committee on Standards for General Practices [NECSGP] which develops the College standards, includes consumer members, and further consults on the Standards with consumers⁴²; BreastScreen Australia^{43 44} includes consumer members in the Standard development Committee, and consumers are also specifically represented on survey teams⁴⁵; The National Pathology Accreditation Advisory Council [NPAAC]^{46 47 48 49} has consumer members; and The Australian Medical Council includes a consumer member on Council and also has consumer representation on its survey teams.

The publicly accessible standards reviewed for this Project encompass principles which have a strong focus on the patient's journey through the care continuum, on the importance of providing high-quality, safe and effective care, and on providing information to patients about their treatment options⁵⁰. The extent to which consumers contribute directly to the development and maintenance of these and other accreditation standards appears to vary by organisation.

The scope for consumer participation in accreditation processes however, is greater than just engagement in the development of standards.

4. 5 Consumer involvement in governance of Accreditation Agencies

The level of consumer participation in international health care accreditation systems varies. A consumer is represented on each of the boards of Joint Commission on Accreditation of Healthcare Organisations [JCAHO] in the USA; Canadian Council on Health Services Accreditation [CCHSA]; Australian Council on Healthcare Standards [ACHS]; Australian Medical Council [AMC]; the Quality Improvement Council [QIC] of Australia and New Zealand; and Quality Health New Zealand [QHNZ]. This is not the case for the Healthcare Accreditation Programme [HAP] in the UK which is strongly based on professional representation.

Outside Australia, the JCAHO system may have the strongest level of consumer involvement. JCAHO has implemented a number of consumer-focused initiatives, e.g. membership on boards and advisory committees, the establishment of a complaints mechanism, and sentinel events register.

Within an Australian context consumer and community participation was an essential principle of the National Health Strategy (1993) as well as being integral to accreditation requirements for hospitals and community health services (Australian Council on Healthcare Standards and the Quality Improvement Council).

The Australian Medical Council [AMC] is an independent national standards advisory body for medical education and training. Its accreditation responsibilities include accreditation of Australian and New Zealand medical schools and medical courses, and Australian/Australasian programs of specialist medical training. Membership of the Council is drawn from a broad cross section of the groups associated with the standards of medical practice in Australia, including nominees of the state and territory medical boards, the universities, the specialist medical colleges, the Australian medical Association, health consumers and the community, the Commonwealth and the States⁵¹.

4. 6 Consumer involvement in Accreditation Survey Teams

Different standards require different expertise from assessors. For example, some standards have a clinical focus, while others may focus around financial, management or systems issues; others have a highly technical focus. It is unlikely that one person will have all the skills required to complete a review in these different areas, particularly in a typical short-duration accreditation on-site visit. It has been suggested that it is appropriate in some cases to establish a team of experts that could include a combination of professional surveyors, industry peers and consumers.

The literature reviewed here reports the accountability of accreditation teams is enhanced by including appropriately trained consumer or community members alongside 'professional surveyors' and industry peers. It also reports that the template or structure for accreditation teams should reflect the varying skill sets as well as the differing experiences of our diverse population. Membership and the model for consumer engagement also need to reflect the diversity in the community.

Two of the major accreditation agencies in Australia, the Australian Council on Healthcare Standards (ACHS) and the Quality Improvement Council (QIC), have introduced consumer surveyors or reviewers into their survey teams for in-depth mental health service reviews. QIC is a national non-profit body which administers the QIC Standards and Accreditation Program in Australia and New Zealand. QIC requires all reviewers to undertake suitable training before becoming a reviewer. Training must address a set of competencies such as preparing for a review, undertaking a review and writing a report for a review. QIC licences a number of providers who conduct the accreditation activities. Each licensed provider has its own arrangements for ensuring that reviewers achieve these competencies. In addition to training, all reviewers are required to undertake regular professional development.

The Australian National Standards for Mental Health Services require consumer participation in the accreditation of mental health services against the Standards and in NZ, where this is a legislative requirement⁵². The AMC's Specialist Education Accreditation Committee develops accreditation policy and procedures as well as overseeing the accreditation process AMC conducts. Health consumers hold full membership of the Specialist Education Accreditation Committee⁵³. AMC constitutes its accreditation review teams to ensure community interests balance those of the medical and educational specialist members, and provides information, training and support for all review team members, including consumer members.

The following Table summarises the current status of consumer roles and involvement in a selection of Australian organisations providing accreditation programs. The nature of consumer involvement is based on the publicly available materials accessed in this project. The reader is referred to the detailed description of the roles and extent of involvement which occurs in Section 4 and Appendix D of the Report.

Organisation	Standards	Governance	Surveyors
Australian General Practice Accreditation Ltd	✓		
Australian College of Healthcare Standards	✓	✓	✓
Quality Improvement Council	✓	✓	✓
Royal Australian College of General Practitioners	✓	✓	
National Mental Health Strategy	✓	✓	✓
Australian Medical Council	✓	✓	✓
National Pathology Accreditation Advisory Council	✓	✓	✓
BreastScreen Australia	✓		

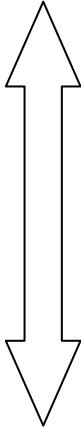
4.7 Models for engaging consumers in health services

Experience of consumer participation in models of collaborative management over the past few decades reveals that there is no universally ‘right’ level of community control or involvement. What is important is that the involvement is meaningful and appropriate to the capabilities and characteristics of the stakeholders concerned. ‘Meaningfulness’ has to reflect the desires of consumers to be engaged in a process that values their contribution and capacity to comment.

One issue is the degree of control or ‘power sharing’ within organisational processes. Nearly three decades ago, Arnstein⁵⁴ modelled the degree of ‘citizen’ control based on the range and intensity of consumer participation afforded. This model illustrates that ‘consultation’ reflects a low level of participation. Consultation is frequently a one-off or short-term process, which is organised around a specific issue or topic and is designed to gain feedback and views about that issue. It tends to be focused on the organisation rather than the user. It has been described more recently as akin to “road testing”⁵⁵ – i.e. giving affected members of the community an opportunity to comment on some policy initiative. Thus consultation may only elicit reactive responses to the issue *as others have framed it*.

‘Participation’ on the other hand, is an active relationship in decision-making and planning processes. It is systemic, formal and on-going. It is embedded in organisational processes, and brings a sharper focus on consumer views of the issues. The consequence is at least an enhanced match between community and service expectations⁵⁶. It is seen as a proactive strategy to address improvements in quality and safety, driving accountability ‘outwards’⁵⁷.

The degrees of consumer participation are illustrated the following table which shows the 1991 reworking of Arnstein’s model, by the UK Health for All Network⁵⁸.

Degree of consumer control		<u>Participant task</u>	<u>Organisation task</u>
High		Have control	Asks community to identify problem and make all key decisions on goals and means; willing to help community at each step to accomplish goals
		Have delegated	Identifies and presents problem to community; defines limits; asks community to make series of decisions to be embodied in a plan it can accept
		Plan jointly	Presents a tentative plan subject to change; open to change from those affected; expects to change plan as needed
		Advise	Presents a plan and invites questions; modification only if absolutely necessary
		Are consulted	Tries to promote plan; seeks support or sanction to facilitate acceptance or administrative compliance
		Receive information	Makes plan and announces it; compliance expected; community convened for informational purposes
		None	Community not involved
Low			

This model sought to make consumers more knowledgeable and pragmatic about health options and expectations, as well as providing them with a formal structure in which their role would moderate the traditional domination of services by professional and corporate interests²⁸.

Consumers are not a homogenous entity – they are as varied, skilled, educated, articulate and competent as reflects the broad community from which they come. Mechanisms for participation need to address this diversity. For example consumers from culturally and linguistically diverse backgrounds may not have the English language competencies to participate directly in accreditation activities, or the mechanisms to seek their input may not accord with their cultural experiences. They may still contribute effectively to quality improvement initiatives with support strategies which enable their participation.

In the absence of a professional background, consumers should not be precluded from participation in the accreditation teams for very technically- or scientifically-oriented services. For example, rather than focusing on the ‘structure’ standards (which may be highly technically oriented) consumer participants could make a particular contribution to ‘process’ standards (i.e. what is done in caring for consumers; the sequence of care delivery; interactions between providers and consumers using the service) as well as ‘outcome’ standards (i.e. attitudes, behaviour and knowledge).

There are some existing templates for consumer participation which are directly applicable to accreditation activities. For example guides provided by the Mental Health Council of Australia⁵⁹ and the Consumer Focus Collaboration, specifically address consumer participation in accreditation. These guides are intended to assist consumer participation as

surveyors or reviewers in accreditation teams or as members of quality improvement committees of health services seeking accreditation. They are targeted to: accreditation agencies; health services which are seeking accreditation; and consumers of health services who are seeking to be involved in accreditation related activities.

Feedback from the stakeholder consultations together with the literature reviewed for this project has highlighted the importance of involving consumers in the standards development and accreditation process. Some of the suggestions regarding consumer input are outlined below.

- Consumers should participate in the governance structures of accreditation agencies, as is the case for ACHS (and JCAHO in the USA) where consumers are represented at Board level.
- Consumers can actively contribute to standards development and assessment processes, not only by being involved in surveys or interviews as part of the assessment process, but also by being part of the assessment team. It is acknowledged that this would require well-educated and trained consumer representatives.
- Accreditation data from consumer feedback or complaints mechanisms can play a valuable role in identifying important consumer concerns with a service, as these may not be picked up by an accreditation process. It is often difficult for site visits to pick up all individual issues about care.
- Consumer engagement should include patients, community members, carers, and representatives from consumer organisations. There is a broad body of work on how to relate to and appoint consumer representatives (e.g. The Commonwealth Consumer Affairs Advisory Council⁶⁰; Consumers' Health Forum; Health Issues Centre).
- Consumer organisations could play an important role in educating the public about the accreditation processes, by working in collaboration with government, health services and accreditation agencies.

4. 8 Barriers to consumer participation

Barriers to consumer participation include attributes of healthcare professionals as much as attributes of consumers themselves. The Australian National Health Strategy (1993) described the

“Power differentials between consumers and providers/administrators as a major impediment to participation in governance and service policy development, planning, management and review processes”.

From a consumer perspective, having a ‘champion’ in the system is important in the promotion of community participation.

Despite some attitudinal change towards the involvement of consumers in health services, consumers still report persistence of paternalism towards them and some intransigence on the part of professionals in protecting ‘their’ interests at all costs^{26 61}. For other consumers, based on their previous experiences, participation tends to occur at the margins of decision making and rarely brings about a significant change.

There is still a gap between the published literature on shared decision-making and patient-centred care, and broader understanding of these concepts and their operationalisation in health service accreditation. Although healthcare professionals often described the need for partnership and placing patients 'at the centre' (for example the Submission to the Commission on the Future of Health Care in Canada argues that patients are the central reason for the health care system), consumers are not systematically engaged in accreditation activities.

Health professionals may need to be equipped with new skills in order to meet these challenges, as well as reconceptualise notions of 'consumer' as well as engagement. Consumer participation is not about usurping authority, or professional or technical skills. Rather it is about contribution of perspectives and understanding. Moore (2003)⁶² questions whether the emphasis should be predominantly on establishing equality in the partnership. She notes that:

"perhaps the focus should be on creating a partnership which is based on mutual trust and one of openness, more so than equality. This would allow for a better relationship between two different groups, than focusing on being equal, which relates more to a shift in power or degree of influence".

Despite the obvious advances in engaging consumers in the processes which strengthen the quality of their healthcare services, there do remain barriers to consumer participation to be overcome. These include attitudes to consumer participation – underpinned by a view that accreditation is the sole prerogative of the technically and professionally skilled, and an attribution made about consumers that they are neither capable nor willing to be involved in quality improvement activities.

Several authors^{63 64} indicate the move to consumer engagement requires recognition that clinicians and administrators are not the sole repository of health/policy wisdom. Consumers have expectations, priorities and their views provide an important balance to other interests. Their participation stimulates review and improvements and provides at least one mechanism for integration of community priorities into policy and practice. Since there is a well-established body of literature which points to the need for engagement of consumers in quality improvement activities, and the benefits which accrue from this, 'evidence-based' practice should reflect this.

For some consumers, opportunities for participation can be impeded by factors other than those related to health services. These include competing priorities, demands on their time, travel or transport issues, as well as lack of confidence and their own health status²⁵. These are not insurmountable barriers, and there is growing recognition that 'opportunity costs' for consumer representation can be addressed by some flexibility in processes as well as recognition of the utility and value of *representative* (c.f. 'expert') contributions appropriately supported consumers do make. There is certainly evidence to suggest that increased community participation in systems planning and delivery can lead to improvements in the quality, safety and accessibility of health care systems and also improve individual and community health outcomes⁶⁵.

The following Table presents a selection of the benefits of, and barriers to (together with possible solutions to the barriers) consumer involvement in accreditation based on the results of the data collecting activities in this Project. This is not an exhaustive list, and the reader is referred to the body of the Report, particularly the Literature Review detailed in Section 4; the recommended Generic Procedure for consumer engagement described in Section 6; and the Key Issues Paper presented in Appendix C of the Report for a detailed discussion of these issues.

Benefits of consumer participation	Barriers to consumer participation	Solutions
Improved consumer confidence in service and quality	Stakeholder misunderstanding of purpose and scope of accreditation	Provide consumer and professional educative strategies, to ensure all stakeholders are better informed about accreditation; facilitate engagement of consumers
Widely recognised signal of adoption of best practice standards; stimulation of organisational review and development	Professional and staff attitudes; selective interpretation of 'best-practice'; limited opportunities for consumer participation	Professional and staff awareness strategies that encourage reconceptualisation of consumer participation and shared decision-making; adoption of evidence-based practice
Improved flow and exchange of information and better use of data and information to support safer care	Limited/restricted access to data underpinning decision-making	Improved consumer accessibility and transparency of data collection systems
Demonstration of accountability and increase in consumer focus of QI activities	Resource issues eg time, remuneration and reimbursement; support and lack of confidence	Provide appropriate training, resourcing and support; facilitate shared understanding of consumer expectations, roles and barriers to participation, including resource barriers; ensure clarity of decision-making processes for all team members
More accessible and effective health services	Limited systemic opportunities for participation; limited roles	Improve understanding of consumer capacity, priorities and expectations relating to participation; adopt a range of methods that facilitate participation including that by otherwise marginalised groups; inclusion of consumers in all quality improvement activities; involvement of consumers in standard setting, governance and survey functions
Introduce perspectives which are complementary to professional/technical perspectives	Power/status differentials impede meaningful consumer participation	Role clarity which enhances mutual trust and openness; find a 'champion' for organisation-wide systemic consumer participation

4.9 Summary

The literature reviewed for this Project represents a convenience sample of that which is available. It included both the 'professional' literature and 'consumer' literature that was readily identifiable and accessible, and published within the last 10 years. It demonstrates that accreditation is a significant quality improvement process that requires significant contribution of those engaged in it, and that consumers have a significant role and contribution to make to all accreditation activities – from developing and reviewing standards, participation in governance of accreditation agencies, participation as assessors or surveyors in accreditation teams, to provision of consumer perspectives about the particular services undergoing accreditation.

It is clear that consumer involvement in the broader health sector is an area of contemporary focus and a recurring question is where and how to engage consumers in a meaningful way at all levels of planning, implementation and evaluation of the health system. Accreditation is increasingly recognised as an important strategy for improving the quality and safety of the health system, but a preliminary scan of published literature suggests there is at this time, limited systematic engagement of health care consumers in quality improvement strategies. There is literature on improving consumer feedback, and the need for greater public accountability through accreditation processes.

The literature recognises that the benefits of accreditation relate particularly to the demonstration of conformance against standards, and that assessors must be well trained and capable of undertaking comprehensive and reliable assessments of performance against such standards. Consumers will need appropriate training; resourcing and support; an organisational commitment; and a shared understanding of why participation is needed and wanted, in order to take a meaningful participative role in accreditation.

There is a practical start in the engagement of consumers as surveyors, for example in mental health services in Australia under the National Mental Health Strategy, or by the Australian Council of Healthcare Standards, the Quality Improvement Council, and the Australian Medical Council. Consumers are also engaged as auditors in NZ, where this is a legislative requirement and consumer auditors are trained to relevant ISO standards. This engagement has triggered discussion about the preparation, competence and responsibilities of consumers who are to be participants in accreditation activities.

The health literature and consumers agree that consumer input constitutes an important part of accreditation. Most national and state governments have health policies and statements which stress the value of consumer *participation* in all levels of the system, and this should clearly apply to accreditation. Clinicians may lead it, but *all* stakeholders have an interest in quality improvement, and all should have a say in the policies that drive it. It appears this process can only really be made relevant to consumers if they actually play a part in its development and application.

5 Brief Survey Responses

A brief survey (Appendix B) was emailed to a limited distribution of key consumer and relevant professional organisations (Appendix E), asking for an agree/disagree response to a suite of questions which focussed on consumer roles, skills and experiences, barriers to participation and resource requirements for consumer participation in accreditation activities which focus on diagnostic imaging. Respondents were also invited to provide supplementary comments and any documentation they considered should be taken into consideration for this project.

The content of the survey was informed by the issues highlighted in the published professional and consumer literature, relevant policy statements and other documents identified in a web search and augmented by our understanding of consumer participation issues. It was intended to provide a contextual anchor (diagnostic imaging) for the issues raised.

Given the timeframe of this project, the opportunity for comprehensive validation of survey content, validity or reliability was not possible. It was outside the scope of this project to trial the survey prior to distribution, however the proposed content was submitted to the College for comment and advice on overall content appropriateness.

It should be noted that the survey was distributed to key peak organisations with an invitation to provide an organisational response, and thus the risk to the validity of the responses is more limited than if individual responses from a small sample were sought. The responses provided have been assumed to reflect an organisational perspective.

It is acknowledged that the generalisability of the survey data is limited. However the survey was intended as one strategy for gaining organisational comments on consumer participation in the College's accreditation activities. The strategy adopted in this project of triangulating commonalities within data sets, assists the validity of the interpretations based on it. A useful extension to this data collection strategy would be the further exploration and confirmation of the meaning to respondents of the data gained.

Brief telephone interviews using the same survey items were also conducted with key informants including those identified by through the RANZCR in order to understand and clarify possible barriers and enablers to consumer engagement.

The survey was distributed to 19 peak organisations identified in consultation with the College. These comprise 8 consumer healthcare organisations; 5 practitioner organisations, including Specialist Colleges, and 8 'industry' bodies, including accreditation agencies. A list of those invited to complete the survey is included in Appendix E of the Report. Responses to the survey were received from 7 consumer organisations; 4 practitioner organisations; and 2 'industry' bodies, thus providing a return rate of 68%. In addition, 3 additional 'industry' bodies and 1 illness-specific consumer peak body completed a telephone-administered interview using the same survey items. This provided a total distribution of the survey to 23 organisations, and a total response rate of 74%.

Responses were collated according to the organisation identified – as peak consumer or professional body. Respondents from the professional bodies also identified themselves as specialists or staff of the peak body. Staff included those holding positions as Executive Officers or Secretary of the respective professional peak body.

Respondents were asked if they considered consumers had a role to play in accreditation activities, including standard setting, governance and oversight and as survey team members.

- Consumers clearly wanted to participate in the standard setting, but as many specialists agreed as disagreed. Staff were emphatic in responding NO.
- Governance and oversight of accreditation activities were roles supported by consumers and specialists (with 1 exception); Staff were equivocal – equal agreement and disagreement.
- Membership of survey team was seen as a role for consumers by the consumers and most specialists (with 1 exception); staff were equivocal – equal agreement and disagreement.

In relation to the skills and experience of consumers which would be required for their participation in accreditation governance or site visit activity, knowledge of accreditation processes; knowledge of diagnostic imaging procedures and services; ability to work as part of a team; verbal and written communication skills were universally supported. Knowledge of diagnostic imaging consumers' needs and issues were considered important to consumers, staff and most specialists alike. Only 1 specialist disagreed.

In relation to barriers to involving consumers in diagnostic imaging accreditation:

- Consumer respondents did not think finding consumers with relevant skills and experience was a barrier, but it clearly was to specialists and staff respondents.
- Clarity of the role for consumers, and clarity of the decision-making processes was considered a barrier to consumer participation by all respondents, but 1 consumer unsure
- Consumer and most specialists (1 disagreed) indicated concerns about confidentiality or privacy were barriers to their participation; staff were equivocal with as many agree as disagree;
- Allocating sufficient resources for consumer support and training was identified as a barrier by all respondents
- Ensuring consumers are supported within professional, technical teams – consumers and most specialists agreed (1 unsure); staff were equivocal with as many agreeing as disagreeing
- Getting valid and reliable consumer feedback in practices was not seen as a barrier by consumers, but was by most specialists and all staff respondents.
- Acceptance of consumer roles by service providers was seen as a barrier by consumers, specialists and staff respondents alike

In relation to resourcing requirements which would be required for consumer participation in diagnostic imaging accreditation activities:

- Assistance in understanding technical and service factors in diagnostic imaging; Training in accreditation processes; Administrative support and reimbursement of costs were considered by all respondents to be required
- Consumers and most specialists thought Payment of fees appropriate to tasks were resourcing requirements; but staff respondents were emphatic in their disagreement with this.
- Peer support was regarded as a resourcing requirement by all consumers and most specialists (1 unsure); Staff were equivocal with as many agreeing as disagreeing.

This is a limited survey. It was of necessity, brief and constructed to facilitate easy completion. It provided a focus on possible issues in relation to consumer involvement in Diagnostic Imaging accreditation activities, and thus anchors these issues in that context.

Respondents had the opportunity to include additional explanatory comments and refer to organisational documents as they required.

6 Generic procedure for consumer engagement

6.1 Overview

The term 'consumer' as used in this Paper signifies those who use or are potential users of health services, and their experiences will reflect this. It is not synonymous with the term 'carer' who may have different experiences and expectations to those of a consumer. 'Consumer representative' is the term used to signify a person committed to representing a broad range of consumer views, usually accountable to a consumer organisation and their constituency.

Consumers are not a homogenous group – they are as varied in experience, skills, education and capacity as the Australian population from which they come. Some have links to consumer organisations and thus are able to develop and represent a broader 'representative' view of a range of consumers, than can a consumer who does not have that contact. If a consumer is acting as 'representative' of a group of consumers, then accountability to that group can assist in bringing the range of views to an organisation.

A generic procedure for engaging consumers in the accreditation activities of the RANZCR has to be underpinned by a sound evidence base. The procedure presented here has been informed by analysis, comment and recommendations on consumer engagement strategies which have appeared in a number of non-government publications (such as those from the Consumers' Health Forum of Australia Inc), publications by State and Commonwealth government agencies, and project reports, such as those of the National Resource Centre for Consumer Participation in Health and the Consumer Focus Collaboration.

It is also underpinned by the evidence derived from the literature review, the commentary provided by survey respondents, and the key issues distilled from these sources, all of which were conducted as part of this Project. It is anticipated that the generic procedure will be capable of functioning as a 'stand-alone' document, however the reader is referred to the literature review and the key issues paper reported elsewhere in this Report which underpin the concepts and activities included in the generic procedure.

The rationale for this procedure is based on a framework of continuous quality improvement (CQI), which recognises that consumers bring a perspective that is not filtered through either a provider or funder prism. It also recognises that there is a business case to be made in relation to the effectiveness, implementation, cost-effectiveness and efficiency of services - the literature illustrates consumer participation results in better outcomes, e.g. through appropriate and safe services; assists in identifying and managing demand and need ('allocative efficiency'); contributes to efficient processes and services eg by avoiding rework – missed appointments ('productive efficiency').

There are challenges to consumer engagement, but these are not insurmountable, as the literature and exemplars from other organisational engagement of consumers illustrates. Much of the involvement is about good practice in organisation. Issues of cost versus benefit of consumer engagement can be seen in relation to the cost of service inefficiency and rework that could be improved, and efficiency savings, service and outcomes insights and process improvements.

As with any stakeholder input, organisation to enable consumer participation requires some effort: The roles and expectations of consumer participants need to be clear at the time of recruitment and understood by all team members; different perspectives have to be acknowledged; appropriate skills (or training and support to gain these) are required by all team members to facilitate effective operation; and consumer engagement is part of a continuous quality improvement process.

For these reasons the generic procedure outlined takes a 'PLAN-DO-STUDY-ACT' [PDSA] cycle approach. The PDSA cycle is a process model for quality improvement that has been used extensively in the health care field in Australia and overseas (see for example Quality Improvement in Practice Ltd; Northern Sydney Health; Australian Council for Safety and Quality in Health Care; Australian Divisions of General Practice; Commonwealth Department of Health and Ageing; Institute for Healthcare Improvement). It was initially developed as a framework for accelerating improvement in a variety of business contexts⁹.

Using PDSA to bring about organisational change has been reported to bring a number of benefits: including rapid identification of problems and successes which can be expected from wider implementation; allowing for early and effective changes to the action plan; facilitation of staff acceptance since the strategy can be tailored to their needs and concerns more readily rather than when instituted as a large-scale change strategy. Change is tested at minimal expenditure of resources¹⁰.

⁹ Langley C, Nolan K, Nolan T, Norman C & Provost L. (1996). *The Improvement Guide: A practical approach to improving organisational performance*. San Francisco: Jossey-Boss Publishers, 1996.

¹⁰ <http://www.rand.org/publications/MR/MR1267/mr1267.ch5.pdf>

6.2 A generic procedure

This generic procedure is informed by analysis, comment and recommendations on consumer engagement strategies in a number of publications. Sources include both non-government organisations such as Consumers' Health Forum of Australia Inc., publications by State and Commonwealth government agencies, and project reports, such as those of the National Resource Centre for Consumer Participation in Health.

In this literature, an effective approach to consumer engagement requires a framework of continuous quality improvement (CQI). In developing this generic procedure, we have identified the key steps within a Plan-Do-Study-Act (PDSA) model. Other CQI models are equally applicable.

PLAN: Identify the expectations and resources for consumer engagement

Key questions	Rationale
In which College activity/ies will consumers be engaged?	Identifying the specific program and work areas for consumer engagement assists in defining the scope of activities and resources required.
What role will consumers perform?	The role for consumers determines related strategies such as recruitment and training, and influences the outcomes of the engagement. For example, is the role to represent the views of a group of consumers, or as an individual consumer providing their own views? Will consumer participants have responsibility for surveying against standards, reporting, validating documentary evidence, liaise with and facilitate community input? Are they providing the 'public interest' role? Is there a match between expectations of consumer participation and the role assigned to them? Clear statements about the role will influence the 'selection criteria'.
What tasks will be required of consumers?	The tasks required of consumers determine recruitment, process and resource requirements. For example membership of a committee will require receipt and review of meeting papers, meeting attendance and participation in meeting discussions and decision making. Are there tasks or service environments which preclude consumer participation? Are there particular skills and experiences such as reporting, interview, assessing, that participants will need to complete tasks? What time commitments will the tasks take?
What is the capacity and readiness of the College area to engage with consumers?	Engaging consumers requires time and resource commitment and often involves managing change within the organisation. Successful engagement is assisted by identifying factors within the organisation that may support or inhibit processes and outcomes and considering strategies to manage these.

Key questions	Rationale
What resources and commitments are required from the consumers?	Consumers engaged in any role are being asked to make a contribution to the College. For example, a brief survey takes time and willingness from the participant; ongoing committee roles may involve several days in time and substantial commitment to understanding meeting papers and issues. Consumers in representative roles may need to undertake consultation activities with their membership organisation/s. Considering the demands and costs to consumers is useful in effectively supporting their engagement.
What resources and commitments are required from the College?	Engaging consumers in activities requires the allocation of resources (eg staff time, reimbursement of consumer costs), processes (eg information materials, logistics support such as travel) and commitment (eg leadership and planning) from the College. Are there strategies (such as 'preceptoring') which will support consumer participation? How will other team members and the organisation being accredited know about the role of the consumer member? Strong organisational commitment (eg allocation of leadership responsibility for driving and coordinating consumer engagement) will enhance consumer participation.

DO: Implement the consumer engagement plan

Key questions	Rationale
Recruit consumers to the position/s	<p>Recruitment is assisted by a statement of purpose and clear role and task descriptions. The sources and processes for recruitment depend on the required role. For example a consumer representative role implies accountability to a constituent group or organisation; whereas providing individual views as a user may be achieved through recruitment in a broader community. Are there ideal 'selection criteria' required for the proposed roles?</p> <p>Recruiting representatives through established consumer advocacy organisations requires recognition of their nomination and selection processes. It may be useful to discuss the proposed role, training and support with the organisation. Recruiting from the general community requires advertising and selection processes. Both strategies affect recruitment timelines.</p>

Key questions	Rationale
Orient consumers to the College environment, structures, roles and processes	Consumer engagement is assisted by an orientation process which informs participants of the context in which they are contributing. Orientation processes and content need to be tailored to the role for example engagement in a committee position will require developing an understanding of the committee's place and functions while engagement in one-off survey or group contributions can be assisted by succinct information sheets or project orientation. Consumer participants will have training needs shared by other participants – understanding of the processes, roles, expectations, standards, timeframes, and quality improvement paradigms which operate in accreditation.
Establish support processes and resources	<p>Engagement in established College activities and processes may prove challenging to consumers unfamiliar with the culture and relationships within the organisation. Leaders of activities can assist by ensuring that consumers are endorsed and supported in their engagement; for example by ensuring equitable treatment within meeting and administrative processes; and by recognising that consumers may initially find it intimidating to work within an unfamiliar group of professionals and service providers.</p> <p>A common experience of consumers is being asked to contribute on an equal basis as other participants, without recognition of inequities between volunteer and paid roles. Recognition of the actual and opportunity costs of participation assists in addressing inequities. For example, secretariat support needs to recognise that consumers may have limited capacity to receive and print large documents; or to incur travel or accommodation costs in advance for later reimbursement. Remuneration and processes for reimbursement of out-of-pocket costs should be established prior to consumer engagement.</p>

STUDY: monitor and review the effects of consumer engagement

Key questions	Rationale
Monitor processes, outputs and outcomes	<p>Consumer engagement is ideally a planned and structured activity with clear goals and objectives. Monitoring of key indicators will assist both review and improvement over time, and especially so if consumers themselves are involved in the development of that strategy.</p> <p>Indicators for engagement and monitoring can be identified in consultation with participating consumers and their organisations. They can include process indicators such as timeliness of meeting papers and arrangements; output indicators such as key activities undertaken; and outcome indicators such as assessment of consumer awareness of College activities.</p>
Review plans and processes in the light of experience	Regular review of the effectiveness of consumer engagement will help identify and reinforce benefits to both the College and consumer participants; and can ensure any difficulties are identified and acted on promptly. This assessment should incorporate the perspectives of consumers and their organisations, as well as other College participants and stakeholders.
Revise strategies for improvements	Adjustment of the processes for consumer engagement, based on regular review, will assist continuous quality improvement and allow further development based on insights and outcomes achieved.

ACT: Make any needed changes to improve consumer engagement and outcomes

Key questions	Rationale
Implement new cycle	Consumer engagement can be seen as a continuous cycle with regular review and adjustment over time. This provides a framework for mutual learning and process enhancement between the College, its consumer stakeholders and membership. Based on experience, changes may be made in a number of the areas above.

Appendix A: Work plan & Timeframe

Stage	Activity	Week											
		1	2	3	4	5	6	7	8	9	10	11	12
	Week commencing	21/3	28/3	4/4	11/4	18/4	25/4	2/5	9/5	16/5	23/5	30/5	6/6
1	Initiate project; confirm objectives												
	Develop literature search strategy; identify key documents & commence review												
	Identify key informants for survey & issues												
	Develop Brief survey schedule												
	Disseminate survey												
2	Collate & analyse survey data												
	Summarise main findings from lit review & survey as key issues paper												
	Select distribution of key issues paper for comment												
3	Draft Final Report (including comments received on key issues paper) for distribution												
	Incorporate feedback into draft Final Report												
4	Final Report												

completed

Deliverable

Project Plan, Timeframe, Budget: due Mar 24

Interim Report: due Apr 29

Draft Final Report: due May 27

Final Report: due Jun 10

Appendix B: Brief Survey Schedule

Quality Use of Diagnostic Imaging Project

REQUEST FOR YOUR ORGANISATION'S VIEWS ON CONSUMER ROLES IN ACCREDITATION OF DIAGNOSTIC IMAGING SERVICES

Background to this survey

The Quality Use of Diagnostic Imaging (QUDI) Project is being conducted by the Royal Australian and New Zealand College of Radiologists over a four year period from 2004 to 2008. It comprises activities intended to assist Diagnostic Imaging (DI) practitioners and services to engage in quality improvement activities including development of guidelines, standards and information. More information on QUDI can be found at <http://www.ranzcr.edu.au/qualityprograms/qudi/index.cfm>

One QUDI activity is researching the roles that consumer representatives might take in the accreditation activities of the College. Accreditation is an important quality improvement activity for the College, and it is intended that this activity will help develop appropriate roles for consumer representatives in accreditation.

The term 'consumer' means patients and/or their carers, and 'consumer representative' means those people representing consumers, usually as a nominee of a membership based consumer organisation.

The College has contracted Tony Wade and Derek Weir of Australia's Health P/L to assist in this part of the QUDI Project. Tony and Derek are conducting a range of concurrent activities including a literature review; this brief email survey of selected consumer organisations and professional groups; and interviews with key stakeholders; to build understanding of how consumer representatives can participate in the College's accreditation activities.

The survey questions are intended to identify possible roles, barriers and enablers to consumer representatives in taking on these roles. Together with the literature review and interviews, the survey will inform a discussion paper on the topic which will be distributed by the College.

In consultation with the College, we have identified your organisation as a key stakeholder. You are invited to complete this survey, and return it by:

emailing it to mail@australiahealth.com

or if you prefer, print and mail it to:

Australia's Health P/L

P O Box 5084

Lyneham ACT 2602.

The Survey is designed to allow easy completion, and we would appreciate your early response. If you have any questions about the survey, or would like further information, you can call Tony or Derek on 02 6257 0260 or email to the above address.

Focus of this survey

Accreditation is defined as the recognition granted by an authoritative body that an organisation has met particular quality standards. In the case of Diagnostic Imaging, accreditation is the joint responsibility of The Royal Australian and New Zealand College of Radiologists (RANZCR) and The National Association of Testing Authorities, Australia (NATA).

Accreditation is a strategy that promotes safety and quality in health care. Practices are reviewed against a set of professional, technical and administrative Standards - *the RANZCR Accreditation Standards for Diagnostic and Interventional Radiology* - which have been developed over time to reflect changes in clinical practice, technology and management systems and are reviewed periodically to maintain their currency.

Accreditation applies to all medical imaging however for this Project the focus is on Diagnostic Imaging. This includes radiology (e.g. X-rays), mammography, Computed Tomography (CAT) Scan, ultrasound, nuclear medicine (e.g. Positron Emission Tomography (PET) Scans and magnetic resonance imaging (MRI).

At present the accreditation of practices is a voluntary activity, but it may become mandatory in the future. Practices seeking accreditation need to satisfactorily complete the RANZCR assessment process. This has two components as shown in the table below: document review and on-site peer assessments.

Accreditation activity	Standards used
Document review	Documents are reviewed against the relevant RANZCR Accreditation Standards.
On-site peer assessments, including <ul style="list-style-type: none"> • Resources, procedures and documentation including the Quality System • Technical review 	On-site peer assessments are conducted using the International Standards Organisation (ISO17025) <i>General requirements for the competence of testing and calibration laboratories</i> and the RANZCR Accreditation Standards

Australian and overseas experience has shown that consumers can contribute to professional services accreditation in a number of ways. This can include membership of committees and teams engaged in standards setting, governance and oversight of accreditation programs; participation as site surveyors; and through the provision of feedback on services provided by practices.

This survey seeks your organisation’s views on these roles and the factors which may assist or limit effective consumer engagement in accreditation of diagnostic imaging services

Please fill in your contact details below:

Name	
Position	
Organisation	

Mailing address	
Telephone	
Email	

Completing the Survey Form

There are 4 sets of questions. Please type "Y" for Yes or "N" for No in the table response columns. If you have additional points for consideration, or want to comment on the items, please insert these under Other/Comments where shown.

If you would like to send us material from existing documents, either cut and paste text at the end of the survey form; or send as an email attachment or by mail.

1. Do you consider that consumers have a role to play in the following DI accreditation activities?

Consumer roles in DI accreditation team activities	Y/N
Contributing to accreditation standards setting for DI	
Participating in governance and oversight of DI accreditation programs	
Participating as members of DI site survey teams	

Other/Comments:

2. Are there particular skills and experience consumer participants should have to participate in governance or site visit accreditation activities?

Skills and experience of consumers for DI accreditation activity	Y/N
Knowledge of accreditation processes	
Knowledge of DI consumer needs and views	
Knowledge of DI procedures and services	
Ability to work as part of a team	
Verbal communication skills	
Written communication skills	

Other/Comments:

3. Do you think there may be any barriers to involving consumers in DI accreditation activities?

Barriers to involving consumers in DI accreditation activity	Y/N
Finding consumers with relevant skills and experience	
Clarity of the role for consumers	
Clarity of decision making processes	
Concerns about confidentiality or privacy	
Allocating sufficient resources for consumer support and training	
Ensuring consumers are supported within professional, technical teams	
Getting valid and reliable consumer feedback in practices	
Acceptance of consumer roles by service providers	

Other/Comments:

4. What do you consider would be the resourcing requirements for consumer participation in DI accreditation activities?

Resourcing of consumers for DI accreditation activity	Y/N
Assistance in understanding technical and service factors in DI	
Training in accreditation processes	
Administrative support	
Reimbursement of costs	
Payment of fees appropriate to tasks	
Peer support	

Other/Comments:

THANK YOU FOR YOUR PARTICIPATION

PLEASE RETURN THIS SURVEY AS SHOWN ON THE FRONT PAGE

TEXT ATTACHMENTS (cut and paste below)

Appendix C: Key Issues Paper

This paper is the summary of key issues identified in the literature and document review, together with the responses to the brief Survey and the Researchers' own understanding of salient issues for consumer engagement in accreditation activities.

The key issues outlined in this paper are drawn from a literature review and the results of a limited survey of peak consumer and professional organisations. Both will be more fully reported in the Final Report of this Project, together with a generic procedure for engagement of consumers.

The literature reviewed for this Project represents a convenience sample of that which is available. It included both the 'professional' literature and 'consumer' literature that was readily identifiable and accessible, and published within the last 10 years. Key issues distilled from this literature are presented in this Issues Paper. A specific Diagnostic Imaging perspective to these issues is provided by summary responses to the survey questions.

A brief survey was developed to augment the data derived from the literature review. Its content was informed by the issues highlighted in the published professional and consumer literature, relevant policy statements and other documents identified in a web search and augmented by our understanding of consumer participation issues. The survey was emailed to a limited distribution of key consumer and relevant professional organisations, asking for responses to a suite of questions which focussed on consumer roles, skills and experiences, barriers to participation and resource requirements for consumer participation in accreditation activities. A response rate of 68% was achieved.

Survey responses were collated according to the organisational recipient - identified as peak consumer or professional body. Respondents from the professional bodies also identified themselves as specialists or staff of the peak body.

The following text presents the key issues derived from the literature, followed by the relevant survey responses, and concluding with any comments on particular implementation issues.

The term 'consumer' as used in this Paper signifies those who use or are potential users of health services. It is not synonymous with the term 'carer' who may have different experiences and expectations to those of a consumer. 'Consumer representative' is the term used to signify a person committed to representing a broad range of consumer views, usually accountable to a consumer organisation and their constituency.

1. Accreditation

Key points from the literature

Accreditation is the process whereby a service is furnished with a credential by an external body which testifies that the service meets predetermined standards. It is a review against explicit standards.

Accreditation offers an objective indication that an organisation, facility or service operates to a consistently high standard, and accreditation processes and standards development have played an important role in improving safety and quality in the Australian health care system.

Increasingly, accreditation agencies are aiming to use the process to stimulate a cycle of continuous quality improvement rather than having the focus of accreditation being a type of summative examination conducted every few years.

The principles underpinning accreditation - continuous quality improvement values and responsive adaptable work practices are regarded as both key aspects in managing change within organisations and as indicators of the sustainability of the organisation.

Benefits of accreditation include:

- recognition given by insurers and other third parties, and by referring professionals
- an increase in staff morale and teamwork through involvement in the accreditation process
- enhancing staff education and providing professional consultation which stimulates quality improvement within the organisation
- organisational support providing information and education
- enhance an organisation's system of risk management
- encouraging consumer confidence
- lending credibility to performance reports
- helping organisations attract a high standard of staff; and
- increasing opportunities to gain funding.

2. Consumers and accreditation

Key points from the literature

In the broadest sense, accrediting bodies acts in the public interest to set standards of practice in a field, to evaluate conformance to those standards by organisations in the field, and to communicate that information to interested parties.

This review suggests there is at this time, limited systematic engagement of health care consumers in quality improvement strategies. This is despite the focus of quality in health care increasingly recognising the assessment of quality has to include the experience of those who receive the service.

Consumers see health services from a different perspective than the people who provide the services, and their experiences which can be invaluable in bringing an extra dimension to traditional ways of assessing quality.

While consumers are concerned with the technical aspects of clinical care, they are also concerned about other aspects of care which have not traditionally been considered as part of quality assurance processes or which may be given less of a focus by some health professionals. They include issues about the coordination and integration of care, communication, access to treatment, provision of information, and respect for consumer rights.

The ACS&QHC Working Group on Accreditation has identified a number of principles that strongly emphasise consumer engagement in accreditation systems in health. These include

- effective consumer engagement throughout the accreditation system, including engagement in the governance arrangements of these systems;

- active contribution to the development of accreditation standards, and active involvement in the assessment of services against those standards;
- consultation with consumers regarding what and how they want the outcomes of accreditation to be reported.
- consumer engagement that includes primary consumers (patients), community members, carers, patient advocates and consumer organisations.

There is a broad range of consumer views about accreditation, which reflects the degree of familiarity with accreditation principles and processes, and involvement in a representative capacity.

Some consumers may misunderstand the principles, processes and outcomes of accreditation in reporting they view it an endorsement or guarantee that the services provided will be safe and of a high quality, and that adverse events will not occur. Such a consumer misunderstanding is not surprising given the developing state of engagement in accreditation processes, and highlights an area for future development.

Informed and engaged consumers recognise that accreditation is a developmental approach to quality improvement – it does not endorse or guarantee quality of care, or prevent adverse events or outcomes in health services, but signifies that an organisation has achieved compliance with specific standards, and reflects adoption of a quality improvement paradigm.

Survey responses

Survey respondents were asked if they considered consumers had a role to play in nominated accreditation activities, including standard setting, governance and oversight and as survey team members. This was affirmed by consumers, the majority of specialists and staff. This response is an encouraging confirmation of the principle of meaningful consumer engagement. There were however some qualifications to the roles consumers could take:

- Standard setting was an area where there was some equivocation in the responses of specialists. Staff of the professional organisations were emphatic that consumers do not have a role to play in standard setting.
- Governance and oversight roles were supported by consumers and specialists, but some staff were not supportive of such a role
- Consumer membership of survey teams was supported by consumers and most specialists, but some staff were not supportive of such a role

These qualifications indicate opportunities for sharing of information about the capacity, willingness and training of consumer representatives to be active participants in all aspects of accreditation. Clarification of the tasks which support each of the accreditation roles may also be invaluable. The qualifications in responses to this question may also represent an opportunity to develop the concept of complementary partnerships between the professional and technically qualified members and consumers who bring the experience of service receipt to shared decision-making.

3. Consumer expectation of involvement in accreditation

Key points from the literature

Consumer expectations of involvement in accreditation vary by level of engagement, organisation and opportunity to participate. This ranges from being interviewed as part of the

assessment process; to being informed of the outcomes of accreditation; to being included as survey team members; to expectation of involvement in remediation processes to meet standards.

Engagement of consumers in accreditation processes is not systematic at this time, however there is an expanding pool of consumers who have trained as consumer representatives, have significant networks, and are supported by consumer organisations, who are interested and willing to participate.

Consumer participation is not about usurping authority, or professional or technical skills. Rather it is about contribution of complementary perspectives and understanding. Consumers expect to be engaged in at least assessment of 'process' standards (i.e. what is done in caring for consumers; the sequence of care delivery; interactions between providers and consumers using the service) as well as 'outcome' standards (i.e. attitudes, behaviour and knowledge).

Consumer organisations can play an important role in educating the public about the accreditation processes, by working in collaboration with government, health services and accreditation agencies.

Survey responses

Consumer respondents noted that effective participation was dependent on the adequacy of preparation – both of the consumer representatives to assume accreditation roles, and of the organisations seeking their participation, and particularly the need for a 'champion' within the organisation to promote consumer participation.

Consumer respondents also noted the importance of their networks and their responsibilities in relation to accountability to their constituencies in taking on roles in accreditation activities.

It is clear that consumers increasingly expect to be involved in determining and assessing quality improvement in their health services, and have some refined views both on the roles that they could undertake, and the contribution they can make to quality improvement. This is valuable information to disseminate to those considering consumer involvement in accreditation. Consumer participation in accreditation ideally should reflect an organisation-wide commitment to a comprehensive consumer participation strategy.

4. Consumer involvement in development of standards

Key points from the literature

Consumers can actively contribute to standards development and assessment processes, not only by being involved in surveys or interviews as part of the assessment process, but also by being part of the assessment team which uses iterative processes to refine and contextualize existing standards. It is acknowledged that this would require well-educated and trained consumer representatives.

There is a variable level of consumer involvement in the development of accreditation standards. This is despite many standards having a strong focus on the continuum of care, on the importance of providing high-quality, safe and effective care, and on providing information to patients about their treatment options. It is also despite a burgeoning literature on the evidence base for involvement of consumers as key stakeholders in health care.

In the UK standards are developed in partnership with members of the public; in the USA, consumer participation in standard development is less clear although consumer involvement in the standards development and revision processes is explicitly required in the ISQuA'S International Principles for Healthcare Standards 2004, Second Edition.

In Australia there are several examples where consumers are explicitly involved in the development of accreditation standards – e.g. for the Private Health Industry Quality and Safety Committee; the Royal Australian College of General Practitioners; BreastScreen Australia; the National Pathology Accreditation Advisory Council; and The Australian Medical Council.

Survey responses

Consumer organisations responding to the survey indicated they supported the involvement of consumers in setting the standards used in accreditation. Some specialists were also supportive but others disagreed that consumers should be involved in this activity. Staff of the professional organisations were not supportive of consumer participation in this activity.

The variation in support of consumer participation in setting standards against which assessment of conformance would take place may indicate a need to re-emphasise the evidence based for consumer participation, and highlight international and local experiences of standard-setting agencies which currently do involve consumers in this task.

Since standard setting and ultimately the assessment of conformance with those standards is a key quality improvement activity, a developmental approach to the standards, the orientation or focus of the standards, their review and evaluation would be consistent with the QI paradigm. Involvement of consumers in this task is appropriate, and should not be seen as a diminution of the rigour of the standards themselves.

5. Consumer involvement in the governance of accreditation agencies

Key points from the literature

There are several examples of accrediting organisations that have consumer representation on their Boards: e.g. Joint Commission on Accreditation of Healthcare Organisations (JCHAO) in the USA; Canadian Council on Health Services Accreditation (CCHSA); Australian Council on Healthcare Standards (ACHS); the Quality Improvement Council (Australian and New Zealand); and Quality Health New Zealand (QHNZ). This is not the case for Healthcare Accreditation Programme (HAP) in the UK which is strongly based on professional representation.

Organisations which have a broad remit on quality improvement (e.g. ACS&QHC) have consumer representation at the Council level, in a range of advisory committees, in working groups and taskforces. This organisation also engages consumers in tender evaluation panels, selection panels. The Australian Medical Council [AMC] which is an independent national standards advisory body for medical education and training, with broad cross-sectional membership including health consumers on its Council and Specialist Medical Education Advisory Committee which develops the AMC standards and oversees its accreditation activities.

Organisations seeking accreditation require consumer participation in their governance structures to fulfill some accreditation requirements (e.g. EQuIP and PIP).

Survey responses

Survey responses indicated unanimous support from consumers and specialists for consumer participation in governance and oversight of accreditation activities. Staff were however equivocal – some agreed, some disagreed that governance and oversight mechanisms were appropriate fora for consumer participation.

The responses of staff in the professional organisations indicates there is scope for an information strategy directed to the organisation, on the evidence based for consumer participation, and which highlight international and local experiences of consumer participation in governance and oversight of accreditation activities. The opportunity for sharing of information about the capacity, willingness and training of consumer representatives to be active participants in governance activities may be invaluable in assisting organisations to strengthen their culture of participation and in overcoming concerns about disclosure of previously ‘inviolable turf’.

Similarly, overcoming uncertainty about the process of consumer engagement and participation and how to work together, is important to establishing collegial working relationships.

It is clear that there are issues relating to confidentiality when ‘outsiders’ enter the governance processes of organisations, but there are sound examples where confidentiality in commercially-sensitive organisations is not threatened by consumer participation. Building trust and overcoming fears is a requirement for organisations and their staff, healthcare professionals, and consumers.

Consumers should participate in the governance structures of accreditation agencies, as is the case for a number of Australian and overseas accreditation agencies. But this level of consumer participation in international health care accreditation systems varies.

6. Consumer involvement in Accreditation Survey Teams

Key points from the literature

In Australia, a number of major accreditation agencies have introduced consumer surveyors or reviewers into their survey teams. Examples include the Australian Council on Healthcare Standards (ACHS), the Quality Improvement Council (QIC), and the Australian Medical Council. In some jurisdictions (e.g. NZ), consumer participation in accreditation teams is underpinned by legislation.

Organisations which currently involve consumers in this aspect of accreditation share an understanding with consumers of why participation is needed and wanted, in order for consumers to take a meaningful participative role in accreditation.

Alignment of consumer capacities and perspectives with survey team roles may be valuable. For example, rather than focusing on ‘structure’ standards (which may be highly technically oriented), consumer members may make a particular contribution to ‘process’ standards (i.e. what is done in caring for consumers; the sequence of care delivery; interactions between providers and consumers using the service) as well as ‘outcome’ standards (i.e. attitudes, behaviour and knowledge).

Accreditation data from consumer feedback or complaints mechanisms can play a valuable role in identifying important consumer concerns with a service, as these may not be picked

up by an accreditation process. It is often difficult for site visits to pick up all individual issues about care.

Membership of accreditation survey teams requires appropriate training of and quality assurance procedures for all members, and in some cases (e.g. QIC) meeting a set of competencies such as preparing for, undertaking and writing a report for a review. Consumer participants will also need appropriate training; resourcing and support; and an organisational commitment to systematic inclusion in survey teams.

Survey responses

Survey responses indicated that membership of survey team was seen as a role for consumers by the consumers and most specialists (with 1 exception). Some staff did not support engagement in this capacity.

As with the previous responses, the variation in support of consumer participation as members of survey teams suggests a strategy to clarify the roles and expectations of consumer participants; demonstrate the experiences of those accrediting bodies who do engage consumers in this activity, and to re-emphasise the evidence base which underpins inclusion of consumers as key stakeholders in quality assurance processes.

Consumer members may take a particular role within accreditation teams, focussing on some discrete aspect of the accreditation such as validation of information, or facilitation of community input, and not acting as a substitute for a health or technical professional.

Accreditation survey teams operate in a collegial manner; good leadership and sensitivity to the concerns of its members is just as important for consumer members as for any other team member.

7. Models for engaging consumers in health services

Key points from the literature

The importance of consumer participation in planning, implementation, and the evaluation of health care is recognised in the literature, health policy documents and in some cases in legislative requirements. There are benefits from engaging consumers – particularly in relation to improving the quality of care, but also in improving exchange of perspectives with decision-makers.

‘Champions’ within health systems can aid in the promotion of community participation, and in the development of an organisation-wide comprehensive consumer participation strategy. Consumer engagement should include patients, community members, carers, and representatives from consumer organisations. There is a broad body of work on how to relate to and appoint consumer representatives.

Consumer participation reflects an active relationship in decision-making. It is systemic, embedded in organisational processes, and brings a sharper focus on consumer views of the issues. Consumer participation drives accountability ‘outwards’, and strengthens the claims to evidence-based practice.

There are useful existing templates for consumer participation in health services generally, and accreditation activities in particular. These guides are intended for accreditation agencies, health services which are seeking accreditation and consumers who are seeking to be involved in accreditation related activities.

Survey responses

Knowledge of accreditation scope and processes; knowledge of Diagnostic Imaging procedures and services, and knowledge of the needs and issues particularly faced by consumers using Diagnostic Imaging services were considered important precursors to engaging consumers in accreditation activities.

Consumers (as other accreditation members) should have the ability to work as part of a team, possess excellent verbal & written communication skills, and have sound supportive networks to ensure appropriate contribution to accreditation activities.

There are sound precedents for engaging consumers – including seeking representatives from established consumer organisations, seeking suggestions from other policy agencies and existing consumer advisory bodies. The choice of individual(s) should match with the understanding of the expected role and scope of participation, including whether the person has an understanding of the needs and interests of consumers more broadly.

A suite of skills may be identified, including communication, capacity to manage timeframes and workload (given the short timeframe for survey visits), interview and facilitation skills. Some consumers already have those skills; many consumer representatives nominated from established consumer organisations have participated in skills training to fulfill their role as representatives, but not all organisations have the resources and capacity to provide this.

Best practice models of consumer engagement demonstrate the need to have clearly defined roles, tasks and expectations; appropriate skills and cooperative working arrangements, including consumer-friendly processes; active support; adequate training and information; and appropriate and adequate resourcing of consumers.

8. Barriers to consumer participation

Key points from the literature

Barriers to consumer participation include attributes of healthcare professionals as much as attributes of consumers themselves. Consumers report the persistence of paternalism towards them and some intransigence on the part of professionals in protecting 'their' interests.

There is still a gap between the published literature on shared decision-making and consumer-centred care, broader understanding of these concepts and operationalisation of them in health service accreditation.

There is some tension between active consumer participation and power-sharing. An emphasis on establishing equality may be less productive than on creating a partnership of trust and openness, particularly awareness of consumer expectations, priorities and experiences.

Consumers also face competing priorities, demands on their time, travel or transport issues, as well as lack of confidence and their own health status. 'Opportunity costs' experienced by consumers for their participation can be addressed by some flexibility in processes as well as recognition of the utility and value of their particular contribution.

Survey responses

Consumer respondents to the survey did not think finding consumers with relevant skills and experience was a barrier, but it was clearly identified as such by specialists and staff respondents.

All respondents identified role delineation for consumers, and decision-making processes as current barriers to consumer participation, as were concerns about confidentiality and privacy.

Allocating sufficient resources for consumer support and training was identified as a barrier by all respondents.

Acceptance of consumer roles by service providers was seen as a barrier by consumers, specialists and staff respondents alike.

Some of the responses to the survey suggest some attitudinal barriers might also exist within organisations at staff level.

Current barriers to consumer participation are not immutable. There is now broad experience on how consumer participation can be facilitated, especially by identification of barriers as the first step to their removal. A developmental approach to engaging consumers in accreditation activities has been demonstrated in a number of organisations, which have committed both time and resources into developing the process.

Issues of consumer commitment in time to training and on-going activities, appropriate remuneration and reimbursement of expenses will need to be addressed, and there are exemplars from a number of organisations, including accreditation agencies where this is the case.

9. Summary

There is a growing body of evidence about the benefits of involving consumers in health services - evidence which indicates that:

- Active consumer participation leads to more accessible and effective health services.
- Effective consumer participation in quality improvement and service development activities in health services is achieved through the adoption of a range of methods.
- Effective consumer participation uses methods that facilitate participation by those traditionally marginalised by mainstream health services.

The literature reviewed for this Project demonstrates that accreditation is a significant quality improvement process that requires a significant contribution of those engaged in it. It also demonstrates that consumers have a contribution to make and can take a complementary role in all accreditation activities – from developing and reviewing standards, participation in governance of accreditation agencies, participation as assessors or surveyors in accreditation teams, to provision of consumer perspectives about the particular services undergoing accreditation.

There is literature on improving consumer feedback, and the need for greater public accountability through accreditation processes. The literature recognises that assessment of conformance to standards requires assessors who are well trained and capable of undertaking comprehensive and reliable assessments. The health literature and consumers agree that consumer input constitutes an important part of accreditation.

Consumers are engaged as surveyors, for example in mental health services in Australia under the National Mental Health Strategy, or by the Australian Council of Healthcare Standards, the Quality Improvement Council, and the Australian Medical Council. Consumers are also engaged as auditors in NZ, where this is a legislative requirement and consumer auditors are trained to relevant ISO standards.

Survey responses from consumer and professional organisations identified as salient to Diagnostic Imaging indicated some variation in support for consumer participation in particular accreditation activities, but support for their engagement overall. These responses have suggested opportunities exist to develop a shared understanding of the potential roles for consumers in accreditation activities, as well as benefits from their engagement.

Participation in accreditation activities requires appropriate training, orientation, information and resourcing for all members, but consumer representatives may have additional requirements which need addressing in order for them to make an effective contribution.

Appendix D: Consumer involvement in accrediting or standards organisations

Standards setting and accreditation processes operating in almost all specialist areas of health care including, for example, mental health, general practice, pathology and ophthalmology.

It should be noted that while many accreditation agencies in the Australian health care system assume the dual roles of standards development and surveying against those standards, some limit their services to surveying against standards developed and/or endorsed by independent bodies. For example, pathology organisations are accredited by the National Association of Testing Authorities against standards developed by the National Pathology Accreditation Advisory Council. General practices are generally accredited by one of two major providers of accreditation services (Quality Practice Accreditation Pty Ltd and Australian General Practice Accreditation Ltd) against standards developed by the Royal Australian College of General Practitioners. The ACHS and the QIC, on the other hand, have adopted a comprehensive approach by providing both standards development and surveying services. Other bodies such as professional colleges and state and commonwealth departments also set standards that are then picked up by bodies such as ACHS and QIC, for example mental health standards¹¹.

AGPAL – Standards address: Practice Services; Rights and Needs of Patients; Quality Assurance and Education; Practice Administration; Physical Factors. The Standards are set by: The Optometrists Association Australia (OAA) for Optometric Practice; and The Royal Australian College of General Practice (RACGP) for General Practice. These professional Colleges involve a wide range of people, including consumers, when it sets the Standards¹²

RACS – Conducts accreditation of office-based surgery, as a voluntary quality improvement activity. Standards include physical facilities, equipment, Procedures for the Sterilisation of Equipment and the Maintenance of Sterile Operative Fields, procedures under anaesthesia, drugs & equipment, staff, patient assessment and transfer, medical records, waste disposal, general (occupational health and safety; quality improvement etc) patient selection guidelines and patient discharge. Standards are set by: RACS – but there appears to be currently no consumer representation in this process.

ADGP - Quality improvement and accountability in organisational structures and processes are largely addressed through ADGP accreditation. Uses National Performance Indicators for Divisions, which were developed under contract to the Commonwealth Department of Health & Ageing by small expert team convened by the Australian Primary Health Care Research Institute at the Australian National University¹³. There is no consumer input in the development of the National Performance Indicators.

ACS&QHC – The Council doesn't perform accreditation itself but refers to recognised providers of health care standards and/or accreditation services including the Australian

¹¹ ACS&QHC (2003). Standards Setting and Accreditations Systems in Health. Consultation Paper, July 2003. Commonwealth of Australia.

¹² QIP website. <http://www.qip.com.au/accreditation.asp?acrid=9> accessed 04/05/05

¹³ Sibthorpe B (2005). National Performance Indicators for Divisions 'Go Live'. PHC RIS Infonet, 9(4):4

Council for Health Care Standards (ACHS), the Quality Improvement Council (QIC) and the International Organization for Standardization (ISO). ACS&QHC includes consumer members on Council and many of its subordinate committees and working groups.

ACHS – Performs accreditation against its own standards - Evaluation and Quality Improvement Program (EQuIP) -accredited by the International Society for Quality in Health Care (ISQua). ACHS has three sets of standards: (1)The Evaluation and Quality Improvement Program standards (EQuIP) (for health care organisations). (2) The EQuIP Corporate standards (for health related organisations, public or private that do not offer direct care, and (3) Certification Standards (for organisations to obtain certification before they implement the EQuIP standards if external recognition is required in a short period of time). The ACHS has consumer representation on the Standards Committee and State and National Advisory In the EQuIP 3rd Edition standards, consumer participation in assessing planning, evaluation and the development of policies and procedures has been highlighted¹⁴

NHMRC - has statutory obligations under the [National Health and Medical Research Council Act 1992](#): to raise the standard of individual and public health throughout Australia; to foster the development of consistent health standards between the various States and Territories; to foster medical research and training and public health research and training throughout Australia; and to foster consideration of ethical issues relating to health. NHMRC has consumer representation on the Council and its Committees¹⁵.

National Institutes of Health (USA) comprises 27 institutes and centres. 15 of the 27 members have consumer /public membership on advisory groups which inform the key functions of the institute or centre¹⁶.

NQF represents all aspects of the healthcare industry, including consumers and patients; public and private healthcare purchasers; healthcare providers; and research and quality improvement organizations. NQF engages in many types of activities aimed at promoting the use of standardized quality measures and indicators, linking quality measurement and reporting to strategies for quality improvement, providing quality improvement leadership, disseminating quality information, and exchanging knowledge and ideas¹⁷.

¹⁴ ACHS website. <http://www.achs.org.au/> Accessed 04/05/05

¹⁵ NHMRC website. <http://www7.health.gov.au/nhmrc/aboutus/index.htm>. Accessed 04/05/05

¹⁶ NIH website. http://getinvolved.nih.gov/advisory_councils.asp. Accessed 04/05/05

¹⁷ NQF website. <http://www.qualityforum.org/txfrequentlyasked.htm>. Accessed 04/05/05

Appendix E: Survey Distribution

Organisation name
Consumers Health Forum of Australia
The Royal Australian and New Zealand College of Obstetrics and Gynaecology
Cardiac Society of Australia and New Zealand
The Royal Australian College of General Practitioners
Australian College of Rural and Remote Medicine
Australian & New Zealand Society for Vascular Surgery
The Australian Council on Healthcare Standards
Australian General Practice Accreditation Ltd
Victoria University, Wellington (NZ)
Health Issues Centre
Health Consumers' Council WA
Breast Cancer Network Australia
HealthCare Consumers Association of the ACT
Australian Council for Safety & Quality in Health Care
Australian Diagnostic Imaging Association
General Practice Accreditation of Australia
Cancer Advocacy Network
Women's Health Action Trust (NZ)
Consumers' Institute (NZ)

Additional Stakeholder organisations contacted

National Association of Testing Authorities of Australia
 Medical Imaging
 BreastScreen Australia
 Australian Medical Council

Professional Organisation websites searched

Australian General Practice Accreditation Limited
 Royal Australian & New Zealand College of Radiologists
 Royal Australian College of General Practitioners
 Royal Australian & New Zealand College of Obstetricians and Gynaecologists
 Royal Australian College of Physicians
 Royal Australian & New Zealand College of Psychiatrists
 Australian College of Rural and Remote Medicine
 Australian Diagnostic Imaging Association
 Cardiac Society of Australia and New Zealand
 Australian and New Zealand Society of Vascular Surgery
 Australian Divisions of General Practice
 Australian Council of Safety and Quality in Health Care
 Australian Council on Healthcare Standards
 Quality Improvement Council
 Commonwealth Department of Health and Ageing
 National Health and Medical Research Council
 National Institutes of Health

National Health Care Quality Forum
Joint Commission for the Accreditation of Healthcare Organizations
National Guidelines Clearinghouse

Consumer organisation websites searched

Consumers' Health Forum
Health Issues Centre
Healthcare Consumers' Association of ACT
HealthCare Consumers of WA
National Resource Centre for Consumer Participation in Health
Women's Health Action Trust
Consumers' Institute.

References

- 1 Rosen, A., Miller, V., & Parker, G. (1989). Standards of Care for Area Mental Health Services. *Australian and New Zealand Journal of Psychiatry*, 23(3): 379-395.
- 2 Australian Medical Council (2002). Accreditation of Specialist Medical Education and training and Professional Development Programs. Standards and Procedures. AMC, Kingston.
- 3 Millennium Behavioral Health Care (MBHC). Health care accreditation for the 21st century: benefits (webpage). <http://www.mbhc.com/benefits.html>. Accessed 14/04/05
- 4 Joint Commission on Accreditation of Healthcare Organizations. Behavioral healthcare, benefits of accreditation (webpage). <http://www.jcaho.org/htba/behavioral+health+care/benefits+of+accreditation.htm>. Accessed 14/04/05
- 5 Bureau of Primary Health Care. JCAHO Accreditation webpage: <http://bphc.hrsa.gov/osnp/JCAHOAccreditation.html> Accessed 14/04/05
- 6 Popovich ML. (1998). Joint Commission on Accreditation of Healthcare Organisations: why become accredited? Benefits and values of Joint Commission accreditation. *Home Care Provider* 3:173-175.
- 7 Treacy, J., & Brosi, J. (1996). How the ACHS helps you evaluate the quality of care. In *The 17th Health Information Management Association of Australia Conference Proceedings* (pp. 110-114). Sydney: Health Information Management Association of Australia.
- 8 Zimmerman B (2002). Managing Change –managing the questions to influence the answers. In *A Submission to the Commission on the Future of Health Care in Canada from: The Good Health Through Good Governance Working Group, 2002*.
- 9 Shaw C. (2001). External assessment of health care. *BMJ*, 322:851-854.
- 10 Whittaker S, Green-Thompson RW, McCusker I, & Nyembezi B. (2000). Status of a health care quality review programme in South Africa. *Int J Qual Health Care*, 12:247-250.
- 11 Skok A, Swerissen H & Macmillan J. (2000). Standards and quality improvement processes in health and community services: a review of the literature. Canberra: Commonwealth of Australia, 2000
- 12 Johnston G, Crombie IK, Davies HTO, et al. (2000). Reviewing audit: barriers and facilitating factors for effective clinical audit. *Qual Health Care*, 9:23–36.
- 13 Davies HTO, Nutley SM, Mannion R. (2000). Organisational culture and quality of health care. *Qual Health Care*, 9:111–9.
- 14 Walshe K. (2000). Developing clinical governance: leadership, culture and change. *J Clinical Governance*, 8:166–73.
- 15 Good Health Through Good Governance Working Group (2002). *Good Health Through Good Governance. A submission to the Commission on the Future of Health Care in Canada*.
- 16 Galvin D (1998). Accreditation as an accountability strategy. In L.R. McConnell (ed). *Accountability from Several Perspectives: A Report on the 20th Mary E. Switzer Memorial Seminar monograph*, 1999.
- 17 Consumers' Health Forum (1996). *Integrating Consumer Views about Quality in General Practice*, CHF, Canberra.
- 18 Public Health Agency of Canada (1986). *Ottawa Charter for Health Promotion: An International Conference on Health Promotion, November 17-21, 1986, Ottawa, Ontario, Canada*. www.phac-aspc.gc.ca/ph-sp/phdd/docs/charter/ Accessed 18/05/05.
- 19 Consumers' Health Forum (2003). *Consumer Participation in the Australian Council of Safety and Quality in Health Care Planning Processes*. CHF, Canberra.
- 20 Australian Council for Safety and Quality in Health Care (2003). *Standards setting and Accreditation systems in Health. Consultation paper, July 2003*.
- 21 ACHS (2005). *EQuIP 3rd Edition standards*. ACHS website <http://www.achs.org.au/> Accessed 19/05/05.
- 22 Kelly B (2002). *Health Issues*. 70:26-29.
- 23 Schyve P. (2000). The evolution of external quality evaluation: observations from the Joint Commission on Accreditation of Healthcare Organizations. *Int J Qual Health Care*, 12:255-258.
- 24 Consumer Focus Collaboration (2001). *Consumer participation in Accreditation. A resource guide*. Canberra
- 25 Johnson A & Bament D. (2002) *Consumer Participation in Safety and Quality at Flinders Medical Centre - the search for a consumer-focused model. Report to Department of Health & Aged Care, Canberra. 2002*
- 26 Coney S (2004). *Effective consumer participation for New Zealand: a systematic review of the evidence Summary for the 2nd Guidelines International Conference, Evidence in Action, Wellington, 1-3 November 2004*. The New Zealand Guidelines Group
- 27 Consumer Focus Collaboration (2001). *Consumer Participation in Accreditation Project Report*. Commonwealth of Australia.

-
- 28 Miller-Chenier N. (2002). Getting Citizens Involved in Health Decisions: Some International Perspectives. In A Submission to the Commission on the Future of Health Care in Canada from: The Good Health Through Good Governance Working Group, 2002
- 29 Consumer and Provider Partnerships (CAPPs) in Health Project (2001). Implementing Consumer Feedback into a Continuous Quality Improvement Framework at Alice Springs Hospital. Report to DHA
- 30 Corrs, Chambers & Westgarth Lawyers (2002). Evaluation of the Australian Pathology Laboratory Accreditation Arrangements for the Commonwealth Department of Health and Ageing. Volume 1: Summary report and recommendations. 17 July 2002.
- 31 Donabedian A. (1988). The quality of care – how can it be assessed? *Journal of the American Medical Association*, 260: 1743–48.
- 32 The Cancer Council Australia, Australian Cancer Network and National Breast Cancer Centre (2005). A core strategy for cancer care: accreditation of cancer services – a discussion paper. 2005 National Breast Cancer Centre, Camperdown, NSW.
- 33 Heidemann EG. (1999). Editorial: the ALPHA program. *Int J Qual Health Care*, 11:275-277.
- 34 ISQuA. (2004). International principles for healthcare standards: second edition. Melbourne. The International Society for Quality in Health Care, 2004
- 35 Clinical Standards Board for Scotland (2002). *Clinical Standards: Generic*. Edinburgh.
- 36 Clinical Standards Board for Scotland (2001). *Clinical Standards: Breast cancer*. Edinburgh.
- 37 National Breast Cancer Centre, (2005). A core strategy for cancer care: Accreditation of cancer services – A discussion paper, February 2005.
- 38 National Health Service Executive (2000). *Manual of Cancer Services Standards*. Department of Health, London.
- 39 Commission on Cancer. *Cancer Program Standards* (2004). Chicago. American College of Surgeons. 2003
- 40 Statement of the American College of Surgeons. Quality and consumer information: physicians to the Federal Trade Commission and Department of Justice. American College of Surgeons Testimony. Washington DC. Presented by La Mar McGinnis. May 30 2003
- 41 PHIQSC. Private Sector Quality Criteria www.phiqs.org.au/stratplan.html. Accessed 17/05/05
- 42 The Royal Australian College of General Practitioners (2004). *RACGP Standards for General Practices (3rd Edition)*, Data for field testing.
- 43 Breast Screen: Evaluation report. BreastScreen Australia.
- 44 BreastScreen Australia (2004). *National accreditation handbook (draft for consultation)*. BreastScreen Australia
- 45 BreastScreen Australia (2002). *National accreditation standards: decision tool to assist with accreditation decision-making against the national accreditation standards*. Breast Screen Australia.
- 46 Australian Government Department of Health and Ageing – “NPAAC – Function” DHA Website: www.health.gov.au/npaac/functions.html Accessed 07/05/05.
- 47 NATA website – www.nata.asn.au Accessed 03/05/05
- 48 Matthews Pegg Consulting (2003). *Standards Setting and Accreditation Literature Review and Report*. Canberra. Safety and Quality Council. (Australian Council for Safety and Quality in Health Care) p.106
- 49 National Pathology Accreditation Advisory Council (2002). *Standards for Pathology Laboratories*.
- 50 National Breast Cancer Centre, (2005). A core strategy for cancer care: Accreditation of cancer services – A discussion paper, February 2005
- 51 Australian Medical Council (2002). *The Recognition of Medical Specialties and sub-specialties. Policy and Processes*. AMC, Kingston.
- 52 NZ Government Health and Disability Services (Safety) Act 2001
- 53 Australian Medical Council website: <http://www.amc.org.au/home.asp> Accessed 16/05/05
- 54 Arnstein S. (1969). A ladder of citizen participation. *Journal of the American Institute of Planners*. 34(4): 216-224.
- 55 Stewart J (2003). Participatory Governance, Power and Public Management. In National Institute for Governance : Facing the Future: engaging stakeholders and citizens in developing public policy. National Institute for Governance and Australian Public Policy Research Network Conference (2003). University of Canberra.
- 56 Non Statutory Community Advisory Committee Guidelines for Metropolitan Health Services 2000; Victorian Quality Council's Victorian Consumer Participation Framework 2003
- 57 Australian Public Policy Network website. www.apprn.org. November 2003
- 58 UK. Health for All Network (1991) (website) <http://independent.livjm.ac.uk/healthforall/> Accessed 19/05/05
- 59 Mental Health Council of Australia (2005). Consumer and carer participation policy template MHCA website. <http://www.mhca.com.au/public/noccs/qic.doc>. Accessed 17/05/05

60 Commonwealth Consumer Affairs Advisory Council (2002). Principles for the appointment of consumer representatives: a process for governments and industry. Consultation draft.

61 Kings Fund (2002). Changing Relationships: Findings from the Patient Involvement Project.

62 Moore K (2003). Consumer And Provider Partnerships: What Makes Them Work. Report to Commonwealth of Australia on The Consumer and Provider Partnerships in Health Project. Canberra.

63 Larson CO, Nelson EC, Gustafson D & Batalden PB. (1996). The relationship between meeting patients' information needs and their satisfaction with hospital care and general health status outcomes. *Int. Journal for Quality in Health Care*, 8(5): 447-456.

64 Hardy GE, West MA & Hill F. (1996). Components and Predictors of Patient Satisfaction. *British Journal of Health Psychology*, 1: 65-85.

65 Victorian Quality Council (2003). Non Statutory Community Advisory Committee Guidelines for Metro Health Services. Victorian Consumer Participation Framework 2003. Policies for Community Participation