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Professor Cliff Hughes
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Clinical Excellence Commission
Level 3, 65 Martin Place
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24 September, 2007

Dear Professor Hughes

Quality Systems Assessment Program – Final Report

Please find attached the final report for the project to develop the Quality System Assessment Program for the Clinical Excellence Commission. The report provides a summary of activities undertaken during the project and together with the accompanying CD containing the tools and templates, are the final deliverables for the project.

I would like to take this opportunity to say how much our team has appreciated the opportunity to be involved in this pivotal development work. Please don't hesitate to call me if you have any questions or concerns.

Yours sincerely,

Liz Forsyth
Partner

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Disclaimer

This report has been prepared using information provided to KPMG by the Clinical Excellence Commission (CEC). KPMG has relied on that information being accurate. KPMG has not undertaken any audit or other forms of testing to verify the accuracy, completeness, or reasonableness of information provided. Accordingly, KPMG can accept no responsibility for any errors or omissions in the information shown in this report where it is based upon that information provided.

This report has been prepared at the request of the CEC in accordance with the terms of KPMG's engagement contract dated 8th January 2007 Other than our responsibility to the CEC neither KPMG nor any member or employee of KPMG undertakes responsibility arising in any way from reliance placed by a third party on this report. Any reliance placed is that party's sole responsibility.

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Executive Summary

This final report is one of the required deliverables for the Quality Systems Assessment program project undertaken by KPMG for the Clinical Excellence Commission (CEC). The report provides an overview of the project methodology, a report on the results of the activities of the project and considerations for the roll-out of the Program. The report together with the finalised activity statements, assessment tools and templates are the final deliverables for the project.

The project has achieved its objectives, to further develop and test the proposed methodology for assessment of the safety and quality systems in the eight Area Health Services, Justice Health and the Ambulance Service within New South Wales. The development work was informed by results of the first stage project; an extensive review of the literature; consultations within the Public Health Organisations (PHOs); and consultation with a number of risk management, patient safety and quality experts from both within health as well as from other industries.

The QSA methodology represents a new and innovative approach to the assessment of safety and quality in health care and incorporates concepts from risk management theory, traditional financial auditing processes as well as a number of regulatory approaches from mining, government and transport.

The assessment tools were developed with guidance on the content of the QSA being provided by the NSW Safety and Quality Program, other key policy documents, Directors of Clinical Governance, the QSA development team, NSW Health and those who participated in the consultation activities.

The assessment tools and methodology were tested through a piloting program in three AHSs, Justice Health and the NSW Ambulance Service. Verification activities were also tested and the feasibility and practicality of using the proposed triangulation approach was confirmed. An assessment of the burden and value of the assessment process demonstrated widespread acceptance of the content and approach to the assessment.

Feedback to those entities that undergo assessment is a key element of the QSA methodology. The methodology allows for development of reporting that will provide meaningful comparison and address issues of relative risk. Reporting on the safety and quality systems to NSW Health is mandated and the QSA will allow the CEC to identify themes, trends, key issues and opportunities for improvement.

Successful implementation and establishment of the QSA as a valuable and important tool for the assessment and improvement of safety and quality systems requires robust governance with key stakeholder representation; ongoing support for the PHOs in their improvement activities; development of policy, guidelines or coaching tools and facilitation of networking opportunities; engagement of front line clinicians and managers; consumer involvement and change activities to address the culture of fear and blame.

This project has successfully developed and tested an assessment framework and methodology which represents a new approach in health and provides the CEC with an opportunity to improve the flow of information between organisations and people within the NSW public health system to improve patient safety and quality systems.

Introduction

Context

In May 2005, the NSW Health Department launched the NSW Patient Safety and Clinical Quality Program. This was in response to both a generally increasing focus on improvement of patient safety and specifically to address issues raised by the Walker Inquiry into events at the Macarthur Health Service's Campbelltown and Camden Hospitals Under this program are a broad range of activities that aim to assess, improve or provide assurance on the safety and quality of patient care in NSW. Activities include the establishment of:

- the Clinical Excellence Commission;
- Clinical Governance Units in each Area Health Service, Justice Health and the NSW Ambulance Service;
- a new incident information management system;
- a process for the systematic management of incidents and risks; and
- the Quality System Assessment (QSA) program for public health organisations.

First stage project

During 2006, the Clinical Excellence Commission (CEC) contracted KPMG to undertake initial work to develop the QSA. Following a comprehensive literature search and consultation with experts, an overarching framework and accompanying methodology were developed for the program. The methodology identified both the scope of the assessment and the initial foundations of how the assessment method would be applied. A proof of concept exercise was then undertaken through a pilot program involving three AHS. The results of this pilot were positive, indicating that the framework was valid, and that the methodology was both feasible and useful for participants at the AHS level.

Project Methodology

To progress the work of the first project further, the CEC contracted KPMG to undertake additional development of the QSA, this time with a focus on developing assessment criteria and tools for health services at the facility and unit level as well as for the Justice Health system and the NSW Ambulance Service. Specifically, the CEC requested that KPMG:

- develop the QSA for the NSW Health System;
- review and incorporate the best practice methods in large scale system audit;
- take into account the existing systems for quality and safety review in hospitals, specifically accreditation;
- provide advice on 'triangulation' methods to identify issues in the quality and safety of patient care through identification of other data sources to complement the QSA activity statements e.g. staff surveys, complaints data, clinical indicator data;
- determine verification methods following self lodgement of activity statements for PHOs at the different levels in the system e.g. AHS, facility or clinical department;
- determine sample size to ensure accurate representation of the system performance in relation to quality and safety arrangements;
- develop reporting templates to provide information on patient safety and clinical quality in NSW to consumers, the public and different levels of the system and to foster improvement in quality and safety systems; and
- develop a methodology for determining prioritisation of key themes for more detailed focus by the system following baseline measurement.

In order to deliver on these requirements, KPMG undertook a comprehensive project methodology throughout 2007. While greater

detail about the activities undertaken throughout this project is contained in subsequent sections of this report, the major components of activity are outlined briefly below.

Project activities

Consultation

The purpose of the consultation activities was to provide an overview of the QSA to get informed feedback on the developing model, test the acceptability and feasibility of our proposed approach, and understand the strengths and weaknesses of current practices in clinical quality and safety.

Consultation activities included:

- consultation with those who piloted the Draft AHS activity statement on the content and style of the AHS activity statement questions;
- a workshop with the CEC Development Team to identify gaps and deficiencies in the methodology from the first phase;
- consultation workshops with stakeholder groups from various levels of PHOs to test the acceptability and practicality of the emerging methodology including the scope of the QSA assessment criteria; and
- interviews with subject matter experts who have specific expertise or knowledge relating to the emerging methodology or the assessment and management of risk at a clinical or service delivery level.

Further detail about the consultation activities and findings can be found in the *Consultation* chapter of this report.

Update of literature and policy review

In order to ensure that any new literature was considered in this second stage of QSA development, a high level scan of the literature was undertaken. The purpose of this scan was to identify any recent, major

developments in the assessment of quality, safety and risk management systems, both within and outside the health system.

Articles were identified either by the CEC, development team members, through the consultation process, or through a search of selected databases, journals and search engines (Pubmed, Medline, MJA, BMJ, Australian Health Review, Google).

The literature review was outlined in greater detail in the interim report. A summary of the major items identified through the literature review can be found in Appendix A.

Development of the QSA methodology

The QSA methodology was developed through building upon the initial work on the QSA conducted by KPMG during 2006. Major influences in developing this more mature methodology include:

- feedback from the AHS pilot program;
- the updated literature review;
- findings from the consultation process; and
- input and advice from the Development Team.

The final QSA methodology, including the framework, its rationale, and how it may be applied to the NSW health system is outlined in the *QSA Methodology* section of this report. This section also outlines the verification methodology.

Pilot program

In order to test the QSA framework and tools a pilot program was conducted across the three major types of PHOs (Area Health Services, Justice Health and the NSW Ambulance Service) in NSW. The purpose of the pilot was to test:

- respondents' perceived value of each question in assessing patient safety and clinical quality activities undertaken at their organisational level;

- the wording of the questions, and whether respondents could understand what was being asked;
- the burden of completing the activity statements, including the time taken to respond by different staff members;
- the feasibility of the online mode of delivery; and
- the usefulness of the proposed verification activities in confirming the accuracy of respondents' answers.

Overall, the pilot process revealed the QSA to be a feasible and useful program. Further detail about the pilot program and its findings are outlined in the *Pilot* chapter of this report

Reporting

The analysis and reporting components of the program will provide the CEC with the information required to facilitate improvement, networking opportunities, the spread of good ideas and foster innovation in quality and safety. To assist in achieving this aim, a number of reporting templates and tools were developed to support the QSA. These include finalised activity statements for multiple levels of each PHO, including report templates for different levels of the system, identifying the structure, nature and level of detail for each type of report and a template for verification activities.

Program costing

A costing of the indicative costs of the implementation and ongoing management of the QSA was undertaken. The costs to both the CEC and AHS were considered in undertaking this process. The major elements of the program considered in the costing estimate include:

- the management and coordination of the QSA program by the CEC;
- training costs;
- development of the QSA database;
- ongoing database management and support needs; and

- annual data analysis and performance reporting.

Further detail about the QSA costing, including specific cost estimates can be found in the *Costing* chapter of this report.

Project Governance

An important component of this project was the role of the QSA Development Team. The Development Team members met regularly throughout the course of the project to provide guidance and advice.

Specifically, the role of the Development Team was to

- review the developing QSA methodology & tools; and
- provide expert advice on:
    - clinical quality and patient safety;
    - stakeholders their management;
    - NSW health systems, processes and infrastructure and the implications for the QSA; and
    - project risks.

The members of the Development Team are listed in Appendix B.

Consultation

A range of strategies to engage with the health system have been planned as part of this project, including workshops, individual interviews, website feedback and pilot programs. The purpose of these consultation strategies is to:

- provide an overview of the QSA to get informed feedback on developing model;
- test the acceptability & feasibility of our proposed approach; and
- understand the strengths and weaknesses of current practices in clinical quality and safety.

This section provides an overview of the major findings of two of these consultation processes – workshops and individual interviews. It should be noted that additional consultation processes were undertaken as part of the assessment tool development and the piloting phase. The critical findings from these processes are outlined in the 'Pilot program' section.

Workshops

During February and March 2007, a total of nine workshops were conducted across the state, involving over 270 participants from the NSW health system. Staff who participated came from a range of areas, including clinicians (doctors, nurses, allied health, pharmacy) quality staff, as well as service, unit and Area managers. Workshops were conducted both in metro and rural areas, in addition to separate consultations for Justice Health and the NSW Ambulance Service. An additional process was undertaken to consult with Directors of Clinical Governance Units of Area Health Services.

Through the consultation process, a number of common themes in participants' responses were identified. These included:

- current patient safety and quality systems are generally reactive in addressing issues rather than proactive;

- there is a need to establish feedback loops on the performance of safety and quality systems between all organisational levels;
- strong governance and systems of accountability is key in supporting patient safety and clinical quality systems and ensuring they are implemented and incorporated into daily practice
- there are many existing assessment and reporting processes. There is a need to ensure that any data collection strategy associated with the QSA is sympathetic to other data collection requirements;
- accreditation is recognised as a method of evaluating patient safety and clinical quality. However it was generally felt that accreditation in action is not well equipped to pick up day to day operational issues;
- IIMS is currently the most visible part of the safety & quality system. Reporting of incidents has significantly improved, but participants were unsure if IIMS has led to increased actions as a result of reporting. The take up of IIMS reporting is not consistent across all professional groups;
- there are many issues and barriers to the use of IIMS as a complete incident management tool, including how the system is used, the time to report, the differential approach by professional groups and remnants of a 'blaming' culture (though this is changing slowly);
- the review of 'small' incidents (near misses, SAC 3, SAC 4) is very limited – i.e. a reactive rather than proactive approach is taken;
- there are pockets of excellence in reporting, investigation and action;
- challenges relating to human and financial resources may lead services to accept lower standards of safety and quality in order to get the work done;
- current performance drivers do not always provide the right incentives for providing high quality evidence based care. There is a concern that the current focus on access is not necessarily

compatible with a quality focus and improvement in patient safety; and

- staff are a critical element in safety and quality systems and low staff morale can negatively impact patient safety.

Participants' Evaluation of the Workshops

At each workshop, participants were asked to provide an assessment of the session through completing a workshop evaluation form. Overall, 234 participants submitted this feedback form providing a response rate of 86% (a total of 273 people attended the workshops). The evaluation comprised a series of closed questions using a four point scale Likert-type scale response as well as a section for any additional free text comments.

The following table summarises the feedback provided by participants in relation to the evaluation form statements. The average score is the average numerical rating (where 1=strongly disagree, 2= disagree, 3 = agree and 4 = strongly agree) attributed by participants to evaluation statements (n = 234). The column 'closest grading' indicates the closest

Statement	Average Score	Closest Likert grading
Today I was provided with sufficient and appropriate information	3.0	Agree
I have a good understanding of the methodology	2.9	Agree
Today's forum gave me enough opportunity to provide input	2.9	Agree
The consultation team were open to ideas from participants	3.4	Agree
The material and tools provided assisted me to understand	2.9	Agree
Questions or concerns were answered/resolved to my satisfaction	3.0	Agree
Overall, the quality of the consultation was good	3.1	Agree

Statement	Average Score	Closest Likert grading
There is enough further opportunity for stakeholders to provide feedback	3.1	Agree
Appropriate people are being contacted to ensure it works on the ground	2.9	Agree

Table 1: Participant feedback from consultation workshops

Participants provide a range of feedback through the free text areas, including these excerpts below:

- "Please look closely at how this can fit in with processes already in place. Accreditation is very onerous in a small facility & I truly believe it does not change practice. My understanding after today is that this (QSA) process may, but it could get lost in the system if it is an 'add on'"
- "Not sure what will be expected of health services with regards to QSA. Hopefully it just won't be another reporting/credentialling process"
- "Need to involve clinicians/ staff at coal face when development of tools for the unit based assessments."
- "Concern that this is yet another project to do when we all have full time jobs as clinicians. However this is a commendable project and hope that the engagement of clinicians occurs in order to make it better for our patients"
- "Looks good - very willing to participate"
- "I understand your assurance that this won't be another reporting process on top of the array of systems in place (IIMS, KPIs ACHS, Numerical profile etc) BUT please make sure that as an aspect of the development phase you seriously look at the info currently collected and collated and not duplicate a further system. We are all getting a bit demented with the volume of reporting requirements and the seeming duplication of reporting efforts."

A more detailed report on the findings of these workshops was submitted to the CEC on March 22 2007.

Interviews with experts

To provide further depth to the consultation process, a series of interviews with individuals was undertaken. These individuals were targeted for interviews because of their particular experience or expertise in some aspect of safety and quality or in the operational management of safety and quality systems. The individuals consulted during the process is set out in Appendix C check. The findings are summarised below:

- there is little agreement with an approach involving the assessment of compliance with NSW Health policies & guidelines. Knowing compliance does not provide a valid assessment clinical quality and safety at the patient care delivery level;

- currently quality of care can slide with little or no consequence other than if there is a Bundaberg type scenario. There is a precedent for outside assessment and regulation of patient safety provided by the OH&S system;

- the QSA should focus on patient outcomes however there are many factors which effect patient outcomes many of which are outside the control of health care clinicians;

- there are specific risks that are identified as having a significant impact but with evidence on effective risk management strategies. Processes of care including falls prevention, medication safety and venous thromboembolism prophylaxis should be assessed. The QSA should also assess formal structures for detecting and analysing incidents and evidence that change has followed identification of deficiencies in care processes;

- one of the fundamental flaws in the current system is the disconnect between the clinical workplace and management. It is reflected in the lack of established means of communicating patient safety risks and lack of coordinated response to recognised unacceptable risk;

- there is no really meaningful way to assess quality and safety at an AHS level, given that the focus should be on clinical care;
- at clinical unit level QSA should:
    - assess evidence of mechanisms for review of incidents, complaints and other identified problems or risks on a regular basis;
    - mechanisms for quick response to incidents and emerging risks;
    - tracking and analysis of adverse events and complications including data systems that allow comparison across different clinicians; and
    - regular peer review which is rigorous and evidence based.
- the CEC should continue to engage with the clinical community and provide to those consulted during the process for scrutiny, any reports or materials developed.

QSA Methodology

This section provides an overview of the final QSA methodology, including the framework, its rationale, and how it may be applied to the NSW health system. This section also outlines the recommended approach to verification.

The QSA methodology has been developed through building upon the initial work on the QSA conducted by KPMG during 2006. Additional major influences in developing this more mature methodology include:

- feedback from the pilot program;
- the updated literature review;
- findings from the consultation process; and
- input and advice from the QSA Development Team.

The assessment framework

There are a number of elements that make up the QSA framework. The assessment process will occur at the following levels of each of the three PHO types:

- for Area Health Services, at the AHS, Network/Cluster, Facility and clinical unit/department levels;
- for Justice Health, at the Area, Stream and cluster/operational unit levels; and
- for the NSW Ambulance Service, at the State, Division and Sector/Station levels.

Throughout this document there will be reference to activities undertaken at different 'levels' of the system. These 'levels' will refer to those outlined above.

The multi-level approach of assessment is an integral feature of the QSA. This approach allows for responses at different levels of the

organisation to be correlated to assess the effectiveness of governance and reporting structures. It is anticipated that this correlation will assist in:

- identifying state-wide policy and program gaps;
- providing a source of verification of self assessment responses; and
- estimating the degree of effectiveness in the implementation of policies, performance monitoring and risk controls.

This multi level assessment process is illustrated in figure 1 below.

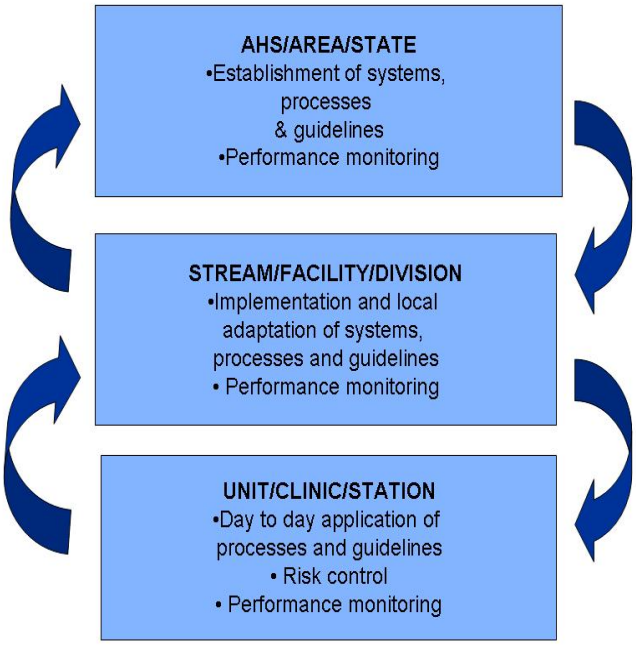

Figure 1: Multi-level assessment and correlation of findings to evaluate the governance system

Assessment of the quality and safety systems and processes in the system will be assessed on an annual basis. The initial application of the assessment methodology will involve a baseline measure of a comprehensive range of clinical quality and safety elements. This baseline measure will need to be reassessed regularly, every five to

seven years. In the intervening years, it is anticipated that there will be a thematic approach to targeted areas of assessment. The nature of these targeted assessments will be determined through the analysis of the baseline assessments, which will identify areas where improvement and focus will be required and hence reassessed. This approach is illustrated in figure 2 below.

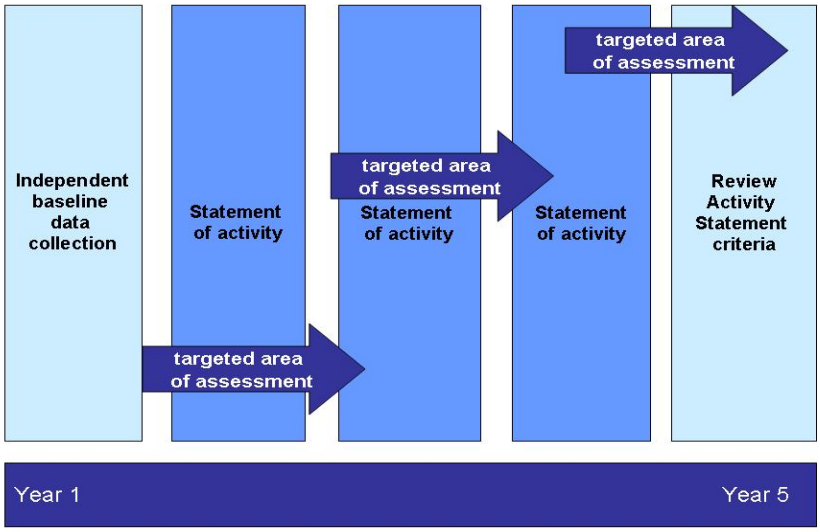

Figure 2: illustration of the structure of the QSA assessment framework

Selection of the targeted area of assessment will be based on the following parameters:

- findings of the previous years QSA in relation to extent and degree of deficiencies in practice;
- an assessment of the degree of clinical risk presented by the potential target area as characterised by its likelihood of occurrence and the severity of impact; and

- advice from a body of experts accessible to the CEC. It is anticipated that existing groups such as the CEC Clinical Council may be utilised for this purpose.

Applying the framework to Justice Health and the Ambulance Service

There are a number of elements of the Justice Health and Ambulance service systems which have required special consideration and modification of the assessment methodology and tools from the standard AHS approach.

Justice Health

Justice Health operate under a number of constraints that impacts the way in which clinical care is provided. Some of the main differences include, but are not limited to:

- access to patients is at the discretion of the corrections staff;
- patients are not voluntary;
- the focus of service provision is around population health, mental health and drug and alcohol; and
- Justice Health is the provider of primary care services to inmates.

The Justice Health system is primarily comprised of a number of clinics operating on a community outpatient model. However, there is one hospital at Long Bay and twelve sites that provide 24-hour nursing services. Services are organised into statewide specialty streams that include mental health, women's health and population health. Clinics are organised into clusters. There are also services that operate within the court system such as Court Liaison Service.

While Justice Health currently undertake ACHS accreditation, a number of areas have been identified where a more focussed assessment process could improve quality and safety systems.

Ambulance service

The NSW Ambulance Service includes four levels within its operational structure: state level, divisions, sectors and stations. A new level, known as 'zones', are currently being implemented throughout the state. Zones will be comprised of a number of sectors. Currently there is no assessment of performance quality by the Ambulance Service through accreditation although ad hoc external audits have been undertaken. For the purposes of assessing quality and safety, the NSW Ambulance Services has advised that three levels be assessed: State, Division and Sector/Station.

The clinical work of ambulance officers is protocol driven and as such offers opportunities for assessment of performance. Some of the main challenges for implementation of QSA in the Ambulance Service include the limited robust data on services and clinical activity, and the isolation of ambulance officers.

Scope of assessment

Guiding policies and programs

In keeping with the framework outlined above, the content of the activity statements will differ according to the level of the organisation being assessed, and the year in which the assessment is being performed (i.e. baseline or target area as illustrated in Figure 2).

In our initial work, we identified the guidance provided on the scope and content of the QSA provided through two NSW Health documents that were developed in 2004: the NSW Patient Safety and Clinical Quality Program (PD2005_608) and the Quality System Assessments-assessment framework (NSW Health, May 2005). These documents provide specifications for the umbrella program, the NSW Patient Safety and Clinical Quality Program of which the QSA is one element.

Within the policy documentation outlining the NSW Patient Safety and Clinical Quality Program it was identified that the QSA should include the following elements:

- an annual review of AHSs to identify, analyse, and advise on systemic issues related to:
    - patient safety; and
    - clinical quality.
- a focus on compliance with standards, policy and guidelines; and
- compliance with the Patient Safety and Clinical Quality Program Standards.

The NSW Patient Safety and Clinical Quality Program identifies seven quality and safety standards to which all Area Health Services are required to comply. These Standards outline requirements for:

- systems to monitor and review patient safety;
- effective clinical governance;
- incident management systems;
- mitigation of clinical risk;
- systems to assess core adverse event rates by medical record review;
- processes for performance review of clinicians by their peers in order to maintain best practice and improve patient care; and
- audits of clinical practice.

Four of the seven standards are underpinned by relevant NSW Health policies and guidelines.

Managing the limitations of the standards

Review of the Safety and Quality Standards indicates that some of the elements of the Safety and Clinical Quality Standards do not have a strong policy base to underpin them. That is, several Standards do not have any policy framework, or existing policies and guidelines are either out of date or do not provide clarity on key elements which may be

assessed. These Standards include the areas of peer review, medical record audit and clinical audit. The developmental nature of these Standards will be managed by two main mechanisms: identifying associated key elements as developmental, and by asking more open-ended questions as a means of assessment.

A critical feature of the QSA framework is that the initial base-line assessment is in many areas non-specific and focussed on fact finding and establishing a picture of the status quo. This will therefore provide the flexibility to assess PHOs' practice in areas where there is both clarity about good practice as well as those where there is not. Further, it is anticipated that there will be considerable variation in the process and nature of these activities within the PHOs and that they may become a targeted area of improvement in the future.

While the existing Patient Safety and Clinical Quality Program Standards will form an important reference for the initial baseline assessment, it is likely that in time, the policies which underpin these Standards will change in response to new knowledge and research. The proposed framework for the QSA is responsive as it allows for new questions to be developed or tailoring of questions to emerging issues of the time. This is further illustrated in Figure 3.

The focus of the assessment is on the systems and processes that are in place to support safety and quality of clinical care. While it is acknowledged that clinical outcomes are the ultimate arbiter of the effectiveness of clinical care, these outcome indicators are established by other professional bodies such as the professional colleges. The Australian Commission for Safety and Quality in Health Care is currently developing an information system to support the identification, collection and benchmarking of key outcome measures. The QSA seeks instead to explore the elements that are in place that support the use of outcomes indicators to drive improvements in clinical care.

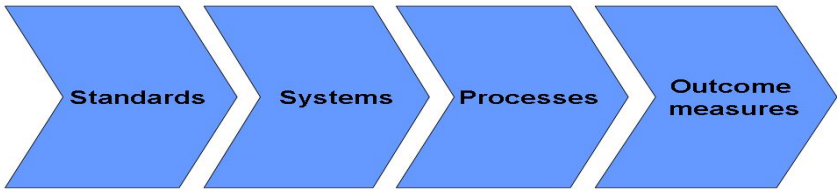

Figure 3: Connection between standards & outcomes

Identifying Roles and Responsibilities

While further detail about complying with each of these Standards is available through the examination of the policies and guidelines which underpin them, these policies and guidelines are aimed at the highest level of the PHO (AHS/Area/State level). As such, they do not identify the different responsibilities of the various levels of the health system. While it is acknowledged that there is some articulation of the responsibilities of the NSW Health Department and the PHOs as a whole through policies such as the *Corporate governance and accountability compendium* or the *Clinical Governance Directions Statement*, there is no direction as to the responsibilities of the other levels of the PHO.

Given the absence of existing guidance as to the roles and responsibilities of the different levels of the health system in the clinical quality and safety arena, a guidance document was developed for each of the three categories of PHOs which outlines the various responsibilities at each level. Specifically, this includes roles and responsibilities for:

- AHS, facilities, and clinical units for the AHS;
- Area, streams and clinics/operational unit for Justice Health; and

- State, divisions, sectors and stations for the NSW Ambulance Service.

In addition, the roles and responsibilities of the NSW Health Department in patient safety and clinical quality have also been identified.

These guidance documents for AHSs, Justice Health and the NSW Ambulance Service are attached at Appendix D.

The assessment model

The assessment model for the QSA has four stages. These include:

- Stage 1 - self assessment of patient safety and clinical quality systems underpinned by risk management principles;
- Stage 2 - verification of the findings of self assessment through audit of a sample of respondents;
- Stage 3 - feedback and reporting to respondents, the health system and the community; and
- Stage 4 - development and improvement of patient safety and quality systems and processes.

These four stages are designed to be an ongoing process, as illustrated in Figure 4 below.

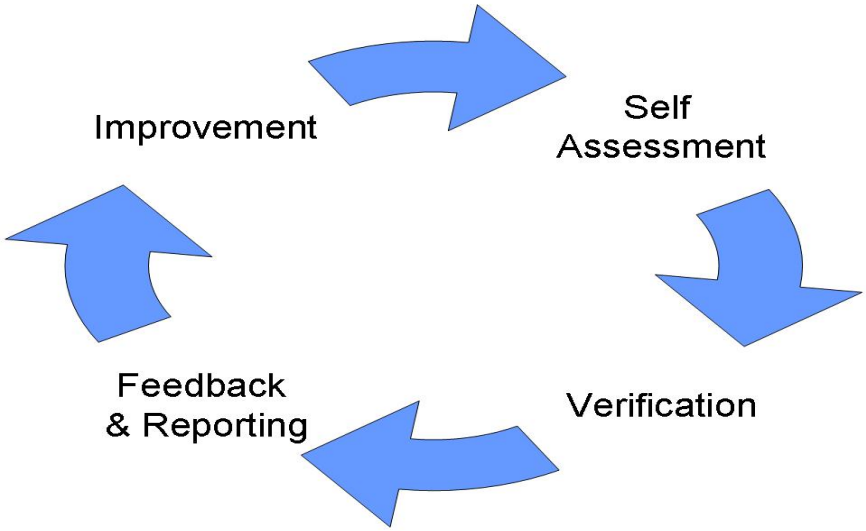

Figure 4: illustration of the assessment model

Stage 1 – Self assessment

The first stage self-assessment process is performed by the relevant level of the organisation and involves the completion and submission of a self assessment tool referred to as an activity statement. Activity statements are available for viewing and completion in an online format, which facilitates the speed of activity statement distribution and significantly lessens the burden of data collection and collation.

As outlined earlier in the methodology, the questions in each activity statement will differ each year, with a baseline measurement in the first year and every five to seven years, and targeted assessments in the intervening years. The purpose of the questions contained in the initial activity statements is to establish a base-line measure through a combination of directed responses and open-ended questions. This base-line measure will:

- identify characteristics of the existing patient safety management system and differences in approach between organisations and levels;

- where possible identify key elements of a robust patient safety and quality system and response chains where they exist;

- be used to help establish improvement aims;
- identify key areas of risk which will be used to inform targeted areas of assessment in subsequent years;
- be used to further develop criteria and questions for subsequent Activity Statements; and
- identify existing risk process control points.

Stage 2 – Verification of self-assessment findings

The second stage of the assessment process (the external audit or verification stage) will incorporate a number of activities. The primary purpose of verification is to determine the accuracy of the responses to activity statement questions. It is important to note that the intention of verification is not to support a punitive approach as it is recognised that incorrect responses are often not intentional; rather, inaccurate responses may be a result of the respondent incorrectly believing that a certain process, system or policy is in place.

The specific nature of verification activities can vary greatly, and when constructing an approach, the verifier needs to consider two main components, the method of verification and the nature of the sample to be verified. Outlined below are some of the possible verification methods and sampling strategies which could be applied as part of verification activities. Each verification method has its own pros and cons in relation to the ease and cost of implementing these methods. A further complexity is that not all questions can be verified by using each of the identified methods.

Methods of verification

There are five methods which may be used to verify the self-assessments. These are:

- same level verification;
- between level verification;
- source of evidence verification;

- desktop review verification; and
- targeted interview verification.

Each of these methods is outlined below.

Same level verification

This verification method uses information from the same level activity statement to verify the accuracy of a given response. To apply this approach, the question being verified must have an associated question both present and answered in the same activity statement (by that same respondent). An 'associated question' is one which asks for some kind of information related to the question requiring verification, and the response which can be used to indicate the accuracy of the target question's response. Not all questions have a corresponding associated question. Further, the strength of the relationship between these questions is variable, with some questions being completely inter-dependent (e.g. if you answered yes to question 1 accurately then you should also have answered yes to question 10), while others have a more loose association (e.g. if you answered yes to question 1 then you should be able to describe an example of this in question 10)

An example of how this same level verification approach might be applied is outlined in the table below:

Level	Unit
Question being verified	10 – Does the unit have a forum/meeting for the discussion of patient safety and quality issues such as indicator performance, incidents and complaints? For example is there are standing agenda item in a staff meeting or Morbidity and Mortality meeting? (*respondent chooses from list provided)*
Associated Question	11 – What information is discussed at the forum/meeting? (*respondent chooses from list provided)*

How the verification is applied	If the response to question 10 indicates a meeting/forum occurs, then there must also be a response to question 11 indicating what is discussed in that forum. If the respondent cannot identify what is discussed, it is possible that the forum does not exist and the answer is not accurate.

Table 2: Example of how same level verification can be applied

Additional examples of same level verification can be found in Appendix E

Between level verification

This method of verification is similar to the same level verification except that question responses are verified through examining the responses provided by related entities of that PHO but at a different organisational level. For example, the response given to a question at AHS level could be verified by a response to a question at Facility level. Sometimes the two questions can be used to verify each other – that is, the correlation (or otherwise) of two questions may identify either an inaccuracy at either level, for example, at the AHS level or the Facility level.

The same conditions as outlined in the same level verification method also apply. That is, the question being verified must have an associated question present and answered (though in this case the question is in the activity statement completed by the other level in the same PHO). The same challenges are also present, including:

- Not all questions have an appropriate 'associated question; and
- The strength of the relationship between these questions is variable.

An additional complexity to be considered in this between level approach is that when looking at higher levels of the organisation (e.g. AHS, Area, Facility, Stream, Division etc), the results from more than one lower level (e.g. clinic, unit, stream) response need to be considered when verifying the response from the higher level.

An example of how this between level verification approach might be applied is outlined in the table below:

Question being verified	AHS 63 – Has the AHS implemented the National Inpatient Medication Chart (NIMC)? (*select degree of implementation from list of options)*
Associated Question	Facility 52 – Has the facility implemented the National Inpatient Medication Chart (NIMC) (*select degree of implementation from list of options)*
How the verification is applied	The responses for these questions should correlate in some manner. For example if the response at the AHS level is that the NIMC is fully implemented in all facilities, then the response to the facility level question should indicate that the NIMC is fully implemented in all units. If the AHS has not fully implemented the NIMC, at least one of the facilities from within that AHS would indicate a less than full implementation in all units.

Table 3: Example of how between level verification can be applied

Additional examples of between level verification can be found in Appendix E

3. 'Source of evidence' verification

This method of verification uses the information identified by the respondent to the question as its 'source of evidence' in the activity statement. This method can only be applied for those questions that ask for a source of evidence, and for which the respondent has in fact completed this field and identified a source.

This approach relies on the judgement of the verifier, who is required to consider the nature of the response to the request for a 'source of evidence' and consider whether it is likely that this source would provide the information suggested. If in the opinion of the verifier the source of evidence seems reasonable, then the response is able to be verified. Conversely, if the source of evidence appears to be unlikely to supply the required information, the response can be considered unlikely to be verified.

While this verification approach is simple, it could be subject to bias from the verifier and it provides indirect evidence only.

An example of how this verification approach might be applied is outlined in the table below.

Question being verified	NSW Ambulance Service – State. Question 20: Please describe procedures in place to communicate patient safety alerts to division, sectors and stations
Response to question	*Details would be provided on the process by the respondent.*
Response to request for source of evidence	Ambulance Circular/Policy (with specific details e.g. date, policy number) for the communication of patient safety alerts
Verification judgement	Its very likely that if there is a specified policy for communicating safety alerts, then the answer provided by the respondent is correct.

Table 4: Example of how the source of evidence verification approach may be applied

4. Desktop review verification

This approach requires the review of information or evidence by the verifier in order to confirm the accuracy of the response to the question being verified. The verifier contacts the respondent to request the information which directed the respondent to choose a certain response. It is then the responsibility of the respondent to provide the appropriate information. If the information source is a document, such as data, minutes from a meeting, or a policy, then this information can be emailed to the verifier. If the source is an individual however, the respondent would need to provide the verifier with the appropriate contact details, and then the individual contacted and asked to verify the accuracy of the given response.

While this approach is reasonably objective, it is also moderately time consuming. The verifier however, can conduct the process remotely,

and is not required to actually visit the site of the respondent organisation.

An example of how this verification approach might be applied is outlined in the table below.

Question being verified	Sector/Station NSW Ambulance Question 3 – Does the sector compare performance of patient safety and clinical quality KPIs with other sectors
Response to question	Yes – compare with other sectors within the division
Response to request for source of evidence	Reports from Divisional Management meeting & associated minutes
Evidence provided on request	An extract of a report discussed at a Divisional management meeting which specify the KPIs and the relevant performance of each of the sectors within that divisions. The minutes identify that this report was discussed.
Verification judgement	Strong evidence that the sectors' performance is examined and discussed is provided. Therefore there is a high likelihood that the respondent's answer is correct

Table 5: Example of how the desktop review verification approach may be applied

5. Targeted interview verification

This verification approach involves the verifier interviewing staff involved in the system, policy or process in order to determine the accuracy of the response. This may be accomplished either by the verifier conducting a telephone interview or a face-to-face interview. As part of the interview process, the verifier may also request documents, such as those identified in the desktop review verification method outlined above.

This approach is by far the most time consuming and is most appropriate for the verification of a group of questions in a particular focus area – for example, incident management – rather than for the verification of isolated issues. It is a useful strategy to obtain richer and more comprehensive information about how quality and safety systems are actually applied at the 'coal face'. This method is also useful because it elicits a perspective other than that provided by the respondent.

An example of how a targeted interview might be applied within Justice Health is described below.

Question being verified	Cluster/operational unit - Question 14(h) and 14(i)
Response to question	Periodic audits of high risk processes and procedures almost always occur. Results of clinical audits are often fed back to staff
Evidence provided on request	Interview of front line clinic staff to identify audit activity and confirm their knowledge about current performance as reported by clinical audit. Review audit tool and any evidence of data or reports to staff. Evidence of frequency of occurrence provided by data, completed audit tools or meeting agenda items
Verification judgment	Interview and observation able to confirm assessment and assess dissemination of reports and access to data by front line staff.

Table 6: Example of how the targeted interview verification approach may be applied

Assessment of the different verification methods

The various strengths and challenges associated with each of the five different verification methods are outlined in Table 7 below.

Method of verification	Pro	Con
Same level	Simple and objective	Requires presence of appropriate 'associated question' - Not appropriate for all questions
Different level	Objective	Must look at multiple responses to gauge accuracy of question requiring verification Requires presence of appropriate 'associated question' - Not appropriate for all questions
Source of evidence	Easy	Subject to verifier bias. Provides indirect evidence only.
Desktop review	Objective	Somewhat time consuming
Targeted interviews	Rich information, perspectives provided other than that of the respondent	Very time consuming

Table 7: Pros and Cons of different Verification methods

Caution in using verification methods.

Some care should be taken when choosing information sources to be used for verification purposes. Depending on the relationship between the question being verified and the other source of information, the discrepancies may serve to highlight a problem in the respondent organisation's processes or systems rather than identify an inaccurate response. For example, in the AHS level activity statement, question 13 (Please list all clinical risks reviewed by the Audit and Risk Management committee (or equivalent) within the period 1 January 2006 and 31 December 2006)) should not be verified using the response of questions 10 (What are the 3 highest risks to patient safety

within the AHS?) If the respondent organisation's risk management systems are good, then their responses should be consistent between these questions. A lack of consistency however could indicate either a poor system (i.e. that the Audit and Risk Management Committee do not review the highest risks to the organisation) or that the responses are inaccurate.

Sampling methods

Not only does the verifier have to select a verification method, but also exactly what is to be verified. This entails the verifier considering both the size of the sample (i.e. how many responses should be verified) as well as the nature or characteristics of the sample (i.e. what type of responses should be verified).

Sample size

Generally, an appropriate sample size can be determined either through sampling the appropriate number of responses required to identify a statistically significant difference between responses, or through choosing to sample based on the nature of the sample. It has been determined that a statistical approach would not be appropriate in determining samples for verification for a number of reasons.

- For Justice Health, Ambulance and AHS level activity statements (ie all except facility and clinical unit) the total population of entities assessed will be small. Therefore to be statistically valid the whole population would need to be verified.

- The verification activities have multiple purposes which include the identification of exemplar sites and characterisation of improvement opportunities. Random sampling will not necessarily provide the information that is sought through these activities.

- A statistical approach may be of most use when considering responses at the unit level (AHSs) where response numbers are likely to be in excess of 1,000. However this approach will not ensure the investigation of performance outliers.

- The variation in question type and content areas casts in doubt the assumption that if one question is likely to be verified another question within the assessment is also likely to be verified.

- To verify all self assessments by all respondents across all sites will represent a significant burden of work. The cost of desktop review of documentary evidence for response and interview verification activities will be a significant burden both to the CEC and to the health system.

Sampling strategy

Certain characteristics of either activity statement questions or the responses given to these questions may be used to identify a sample for verification activities. Examples of sample characteristics include those determined by:

- demographic features (e.g. responses from rural respondents);

- the nature of the responses received (e.g. questions to which responses were highly variable); or

- the nature of the questions themselves (e.g. responses to questions that are in topic areas for which there is little policy direction).

Table 8 below provides a list of areas to consider in determining a targeted sampling strategy.

Sample characteristic	Example
Content area	Responses to Incident management questions
Geographical location	Responses provided by rural and remote respondents
Medical domain	Responses from all ambulatory care units/departments
Degree of policy direction	Responses to questions which have very little

Sample characteristic	Example
available	policy direction underpinning it such as clinical audit
Degree of variation in answers	Responses to questions where the responses are highly variable
'Hot' topic of the day	Responses to questions about issues that are of special political, public or policy interest – likely due to issues outside the control of the CEC
Degree of importance to quality and safety	Responses to questions about issues that are perceived to be essential to quality and safety

Table 8: Areas which could be targeted in a sampling strategy

Implementing the verification approach

As outlined above, there are many options available to the verifier in relation to both verification methods and sampling strategies. In practice, the verifier is likely to use a combination of these verification methods and sampling strategies in order to verify activity statement responses. A number of factors will most likely determine the choice of verification methods. For example, the staff resources available to the verifier, the length of time available for verification activities or the number of responses which are to be verified may all affect the verifier's choice of method.

Similarly, the sampling approach may also be determined by multiple factors. Issues might include the nature of any quality and safety contextual issues which are receiving particular attention, or the need to explain highly variable performance in a particular area. Another consideration which should be taken into account when determining the sample is the potential for the verification process to add value to the overall QSA program. While the purpose of verification is primarily to determine the accuracy of a given response, the verification process may also provide the opportunity to gather a degree of detail which is not elicited through the activity statement questions. This detail can be used by the CEC to further inform support activities such as the

identification of areas in need of state wide improvement activities, or the development of best practice guidelines.

A number of sample focus areas may provide this additional value. Some examples include:

- Samples chosen because of the degree of available policy direction which underpins the questions has currently very little by way of NSW Health driven policy direction. For example, clinical audit has a small section in *The Clinicians Toolkit (2002)* but has no contemporary definitive direction on essential elements of the activity. Verifying clinical audit activity will provide the CEC with additional detail about current or best practice.

- Samples chosen because of the degree of variation in responses. For example high variability in performance in a particular area. Verifying in an area which has highly variable performance may provide the CEC with further insight as to how to translate the good practice of high performers into better results for those with less favourable performance results.

- Samples chosen because of the political or policy impetus of the day. For example there may be a particular focus on an area (e.g. credentialing) due to the political or public environment of the time. Further detail gleaned through verification activities may serve to either reassure policy makers or the public about current standards, or facilitate the development of better practice in the area.

Stage 3 – Feedback and reporting

Results of the assessment process will be reported to relevant stakeholders. Reporting is a critical element in the improvement cycle and will provide feedback on individual performance as well a comparison against other organisations. Wherever possible, these require stratification to allow a comparison within peer groups , identify areas for improvement and inform action plans.

Reporting to NSW Health system will provide information on systems issues and assist in identifying strategies to improve patient safety and clinical quality systems. This may include identification of a need for specific initiatives, policy development or resource issues.

Public reporting has been identified as an important element of the QSA program. Aggregated results will be reported to the public and needs to be part of a wider communication strategy to address concerns about the safety and quality of public health services. As the QSA continues to develop there is a need to consider, reporting of performance between entities stratified for peer group and reporting of individual factors using statistical techniques that provide meaningful comparison and address issues of relative risk.

Further details about the reporting process can be found in the *Reporting* chapter of this document.

Stage 4 – Improvement and monitoring

A critical element of the QSA is its focus on improvement, rather than assigning a pass or fail attribute. Analysis of the baseline assessment results is likely to identify areas where there is poor and/or inconsistent performance across the NSW health system. Once these areas have been identified, educational materials and practice improvement tools to assist health services in making change can be provided. Where performance is inconsistent, exemplar health services with good practice can be identified and learnings from their approach disseminated across the system. The following diagram (Figure 5) illustrates this process.

There are a number of elements of the QSA that will assist in ensuring the delivery of its improvement aims. These include:

- the collaborative, multidisciplinary approach to the self assessment process;
- the development of improvement plans to address gaps in safety and quality systems identified by the assessment;
- the role of the Clinical Governance Units in the assessment process and in identifying opportunities for local improvement initiatives; and
- the incorporation of an integrated risk management approach encouraging process improvement through risk ownership and control.

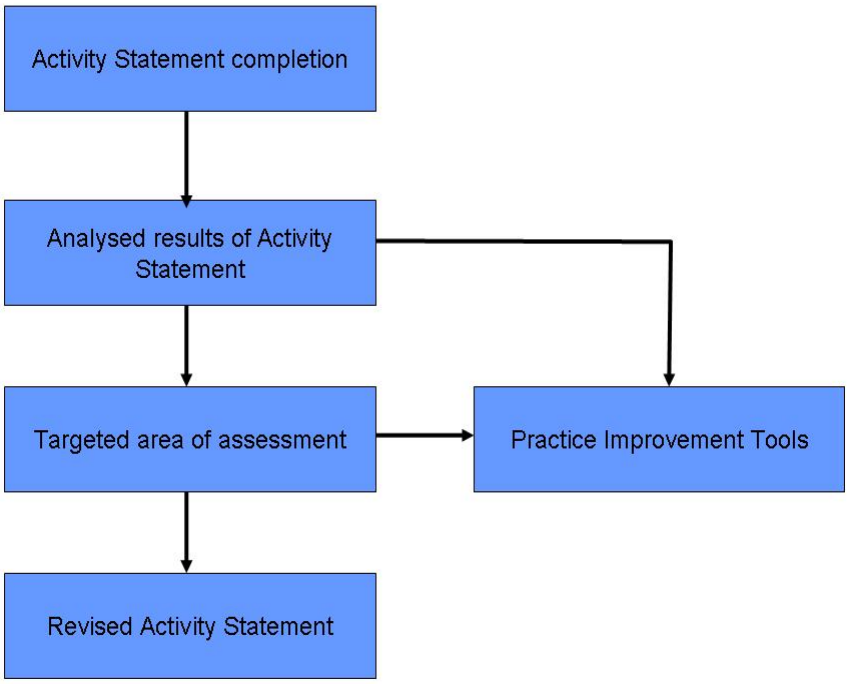

Figure 5: The QSA's responsiveness to assessment results and the identification of new knowledge

In the event that an action is taken in response to findings resulting from the QSA, these actions should be graduated and proportionate to the risk presented. To maintain the integrity of the improvement focus of the QSA, any action other than improvement strategies must be managed by the NSW Health Department.

Developing the activity statements

The QSA must be flexible and responsive to the changing needs and priorities of the health system. To achieve this the scope and content of the assessment tools must be reviewed and revised prior to each assessment cycle. As relevant policies or guidelines are developed or as significant risks to patient safety and quality are identified the operationalisation of these will need to be assessed. This should be done keeping in mind the need to retain the ability to assess the

system longitudinally and identify progress over time. So, common elements need to be retained for periodic baseline measures.

Developing Activity Statement questions

A consistent process was used to guide the development of the individual questions contained in each activity statement. For the initial base line measurement, a set of 'key elements', that should be in place to support patient safety, were identified. These key elements were identified through a combination of the NSW Health policies and guidelines and the relevant level of the roles and responsibilities document (see Appendix D). For an example of key elements in the credentialing process see Appendix F.

Once the key elements for each PHO level were identified, a series of corresponding questions were written which assess the extent to which these elements are in place. These questions are mainly closed in nature. Where there is a lack of guidance as to what constitutes good practice from the policy, questions are open. The questions may consider a number of dimensions relating to risk management. The following table lists the dimensions for assessment.

Dimension	Type of questions
Control environment	Organisation, clinical governance, credentialing, culture and teamwork
Risk assessment	What are the major risks to patient safety/quality of care in your AHS/Facility/stream/unit? Provide rationale
Control activities	What strategies/controls/ are in place to manage these risks or prevent incidents? Is policy/guidelines/IT support appropriate?
Information & communication	Where action is required how is this communicated internally & externally? Is there a feedback loop to staff collecting control data?

Dimension	Type of questions
Monitoring	How does management review performance of controls? Evidence of identification of deficiencies and corrective action.

Table 9: Dimensions assessed in the QSA

The following diagram illustrates the process which underpins activity statement question development.

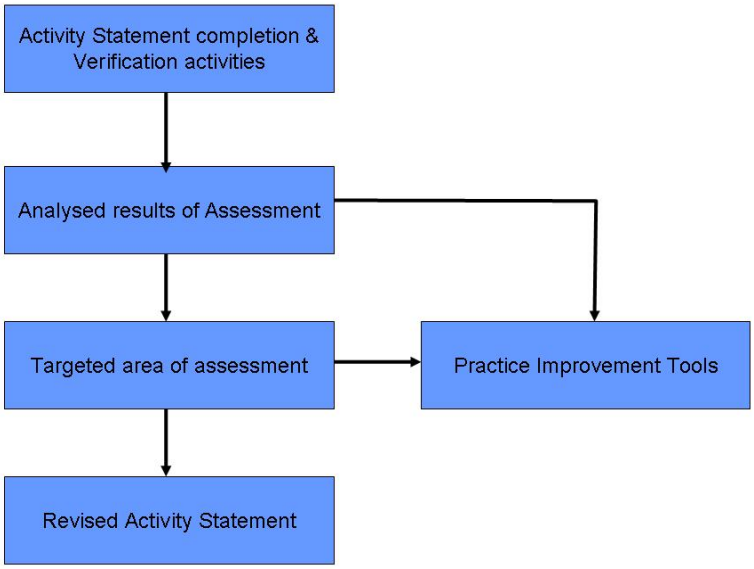

Figure 6: Development of activity statement questions

Relating the framework to the patient

The purpose of the QSA and the NSW Health Patient Safety and Clinical Quality Program's ultimately rests in the provision of high quality health care to patients. The roles and responsibilities of each level of the system relate to their role in providing this care. For the care provider (i.e. unit/clinic or sector/station level), this role may relate directly to the provision of clinical care. For the AHS (or Area/State) and facility (or

stream/divisional) level, these roles may be more focussed on providing the systems and infrastructure such that clinicians are supported in delivering this high quality and safe care.

The QSA methodology acknowledges that patients have expectations of their care. The main elements of these expectations have been identified in the NSW Health Patient Safety and Clinical Quality program. These expectations include[1]:

1 Appropriate treatment for my condition when I need it

2 The best possible care at all times, based on the latest evidence

3 To be treated with respect and have easy and honest communication with the doctors, nurses and other health care professionals who are providing care to me

4 To be looked after by clinicians who have the necessary clinical skills for the work that they do

5 Those who provide care to me are well-supported and part of effective teams, and have access to the resources (including equipment and information) they need to do their work

6 Systems are designed to prevent inadvertent or accidental harm to me while in hospital

7 If I have concerns, I will be able to talk to someone immediately and have my concerns addressed to my satisfaction

8 If something goes wrong with my care, that there is a system in place to openly report, investigate and fix the underlying problems so that others are not harmed. In addition, I will be told openly and honestly what went wrong and receive an apology

9 Reassurance that there is an external body evaluating the safety of care in hospitals and working to improve quality and safety in the NSW health system.

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[1] NSW Patient Safety and Clinical Quality Program. PD 2005_608

10 The QSA assumes that if all parts of the health system fulfil their roles and responsibilities in relation to patient safety and clinical quality, these patient expectations can be fulfilled.

Relationship to accreditation

Throughout the development of the QSA, the issue of its relationship with existing ACHS accreditation has been raised. Specifically, there has been concern that the QSA will duplicate the assessment of quality and safety processes in NSW health organisations. Given this concern, the project team undertook an analysis of the similarities and differences between the two systems. As part of this analysis, the possible use of materials collated for ACHS accreditation activities for verification of QSA questions was considered.

A number of activities were undertaken to determine the relationship between accreditation and the developing QSA methodology[2]. These included:

- consultation with ACHS representatives;
- consultation with pilot sites who had completed both systems; and
- a mapping exercise to determine the degree of overlap between the criteria of Equip 4 and the questions in QSA activity statements.

From these activities, it was determined that:

- there was little overlap between the two systems, as not only were the questions asked in the assessment process dissimilar, but the methodologies themselves were quite different. While it was possible to identify ACHS criteria which were similar in topic/focus area, none of the criteria asked the 'same' question;

[2] Where examination of materials relating to ACHS accreditation occurred, those relating to Equip 4 were used.

- according to feedback from the pilot program, the health system identified the QSA as a separate, value-adding and non-duplicative process when compared to ACHS accreditation activities;

- many facilities are still using Equip 3 materials, and estimated that it would take up to one year lead in to convert to Equip 4;

- the usefulness of materials collated for ACHS accreditation activities for the use in QSA verification is low because of the lack of similarity between questions and because facilities dissemble accreditation materials after use; and

- ACHS accreditation covers only two PHO types (Area Health Services and Justice Health). There is no accreditation occurring of the NSW Ambulance Service.

Further detail and the results of the mapping exercise are contained in Appendix G.

Pilot

In order to test the QSA framework and assessment tools a pilot program was conducted. The purpose of the pilot was to test:

- respondents' perceived value of each question in assessing patient safety and clinical quality activities undertaken at their organisational level;
- the wording of the questions, and whether respondents could understand what was being asked;
- the burden of completing the activity statements, including the time taken to respond by different staff members;
- the feasibility of the online mode of delivery; and
- the usefulness of the proposed verification activities in confirming the accuracy of respondents' answers.

Pilot methodology

Activity statements were tested in all three major PHO types – Area Health Services, Justice Health, and the NSW Ambulance Service. Specifically, within the Area Health Services activity statements were piloted at AHS level, facility level and unit/department level; within Justice Health activity statements were piloted at Area level, stream level and clinic/operational unit level; and within the Ambulance Service activity statements were piloted at State level, Division level and Sector/Station level.

The identification of pilot sites occurred in collaboration with the CEC and the AHS (or equivalent), with consideration given to the breadth of sites and structures which needed be tested. A summary of the number of sites who participated in the pilot are listed in the table below:

PHO type	Activity Statement Level	Number of sites in pilot
AHS	AHS	3
AHS	Facility	4
AHS	Unit/Department	60
Justice	Area	1
Justice	Stream	2
Justice	Clinic/ Operational Unit	5
Ambulance	State	1
Ambulance	Division	4
Ambulance	Sector/Station	5

Table 10: Number of sites participating in pilot by level and PHO type

A full list of the pilot sites including detail about the position and/or professional group of the person coordinating the response is found in Appendix H.

A number of activities were carried out as part of the pilot program. These are outlined below:

1 A kick-off teleconference was held for pilot sites prior to the pilot commencement. A separate teleconference was held for AHSs, Justice and Ambulance. This enabled timing to occur at the commencement of the relevant pilot period. At this teleconference sites were briefed on the purpose of the pilot, the materials to be provided and the sources of support available.

2 An email was sent out to all identified contacts at pilot sites. This email provided sites with:

- a link to the online activity statement;
- a username and password to access the activity statement;

- a PDF copy of the activity statement questions;
- information about how to access the survey and how the information collected in the survey would be used (privacy information) and
- a feedback form (excel spreadsheet) to be completed by respondents asking them to rank questions in relation to their burden and value, provide suggestions or comments about each question's wording, and identify the total time taken to complete the activity statement for any staff members involved.

3 Following the distribution of the activity statements, a period of 3-4 weeks was provided to respondents to complete the activity statements

4 A follow up teleconference with all pilot sites was held within a week following the deadline for completion. At this teleconference sites were provided with the opportunity to discuss their experiences in completing the activity statements and provide further detail in relation to the value and burden of both the questions and the mode of delivery.

5 Where indicated, a number of face-to-face meetings with participants were held to access detailed more detailed feedback on the pilot program.

6 Verification activities

A flow chart of these activities is illustrated below in figure 7

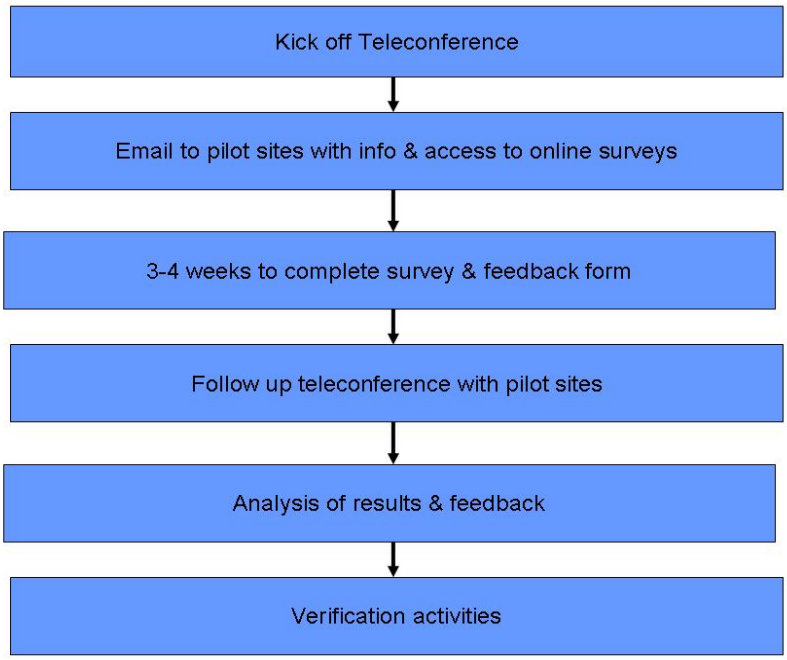

Figure 7: The Pilot process

Major Findings

A range of types and sources of feedback were sought about respondents' experiences through the follow up teleconferences and feedback forms. The major themes of this feedback is summarised below.

What worked well

Through the feedback processes, a number of positive features of the QSA were identified. Some of the most commonly cited strengths of the QSA identified during the pilot are described below.

- **It helped raise the profile of safety and quality.** It was reported that the process of completing the activity statement helped raise the profile of patient safety and clinical quality and that the questions were comprehensive and appropriate.

- **It helped expose weaknesses.** The process of identifying the information needed to answer the questions exposed weaknesses in current practices, that is:
  - it exposed where there was a lack of clarity about what really happened, e.g. lack of consensus between managers about Q&S processes; and
  - it helped rationalise where energy should be focussed: e.g. realised that Q&S improvement project priorities were not consistent with the three highest risks identified.

- **It provided future direction**. The questions themselves provided a snapshot of 'where we should be in the future' and highlighted what was missing currently
  - e.g. credentialing occurs for professions (e.g. surgery) but not for specific procedures (e.g. Whipples procedure)

  In response to this, one of the pilot sites is working on an action plan to address some of the issues identified through the process of participating in the QSA pilot.
- **It made respondents question how they were sure**. The process of answering questions made services question how they were sure certain activities / processes were in place.

- **It was quick and easy to use**. The online mode of delivery was identified by many participants as being quick, easy to use and a good way to deliver the survey.

- **It was not duplicative**. The questions themselves were not considered to duplicate any existing assessment or reporting initiative in any of the PHO types.

Overall, participants from all PHO types identified the QSA as being generally a positive and useful experience –"The QSA was less painful than I thought it would be" (Pilot respondent).

Major issues and challenges

A number of issues and challenges were also identified by participants. Some of the most commonly cited challenges were:

- **The timing of the survey**. Respondents identified that when the QSA is rolled out, the following timing issues should be considered
  - the time of year, it being best to avoid winter when services are stretched; and
  - ACHS accreditation activities – those conducting the QSA need to be mindful of other demands on staff time related to quality and safety assessment and reporting.
- **The time required to complete the survey**. Respondents suggested that at least three months be allowed for their responses, particularly at the facility and AHS level. This time was needed for:
  - access to time at scheduled meetings e.g. executive;
  - contacting and waiting responses from staff responsible for certain activities; and
  - time to identify 'evidence for response' appropriately.
- **Use of online technology in rural / remote locations**. While overall, respondents identified the online mode of survey delivery as a strength of the QSA, there were some issues for respondents at Justice Health and the clinical unit level in rural/remote settings. Specific challenges they faced were difficulty in physically accessing a computer (the ward computer was often used by the ward clerk), slow download times due to poor connections, and general lack of familiarity in using the internet.

Assessment outside the traditional three tiers in AHS

During the development of the methodology, the consultation process highlighted the concerns of stakeholders in relation to whether quality and safety systems, policies and processes should be assessed for

clinical streams or at cluster/network level, and if so, how it should be assessed. As such, Area Health Services with each of these management structures were included as part of the pilot process.

Assessment at the stream level

Activity statements were provided to Women's & Children's Health stream at Northern Sydney Central Coast AHS. Staff from the stream advised that none of the activity statements were appropriate for the assessment of quality and safety processes and activities by streams. Further, feedback was given that in fact the responsibilities for these quality and safety processes and activities lay at the AHS, facility and unit level, not the stream level.

This feedback reflects both the immaturity of the stream structure in AHSs, as well as the 'matrix' like orientation of the stream in relation to both its role and responsibilities. It is likely that until the role of the stream in relation to quality and safety processes becomes more clearly defined, assessment by a method such as the QSA will remain inappropriate.

Assessment in AHSs at the cluster/network level

In consulting with AHSs there was noted to be variability in the degree to which Network/Cluster management have operational responsibility and accountability for elements of patient safety and clinical quality. As a key component of many of the AHS organisational structures it was determined that the Network/Cluster should complete an activity statement in some instances. The requirement for completion of an activity statement should be determined by the functions which have been allocated to them by AHS Executive and by the extent to which hospitals, facilities, services or clinical units rely on the Network/cluster to deliver safety and quality systems and processes.

As part of the pilot, one GWAHS cluster manager completed the facility level activity statement. Feedback identified that this particular activity statement was too detailed and asked questions appropriate to lower levels of the organisational structure but the nature of some questions were appropriate. Another GWAHS cluster manager was then contacted to trial the AHS level activity statement. It was determined

that with some modifications this was appropriate for self assessment of Networks/Clusters.

Other issues

Facility size

Prior to the pilot process, it was identified that there would be some facilities (e.g. 30 bed hospitals or Multipurpose services) for whom the facility level activity statement was not appropriate. Facilities such as these were instead sent the clinical unit activity statement. Feedback from respondents identified that this was an appropriate approach and that all C2 or higher level delineation facilities that are greater than 50 beds should complete a facility level statement. This requirement may be modified where it is determined that functions usually managed by facility management are carried out at the Network/Cluster level. It would be prudent to provide AHS with some guidelines as to who should receive unit vs. facility activity statements during the statewide roll-out.

Relationship with accreditation

Respondents, especially those from the facility level, identified that the QSA was a different process asking for different information when compared with ACHS accreditation and that any duplication was minimal.

Coordination of the activity statement response

While a range of staff members from PHOs were involved in completing the activity statements, a primary point of contact was identified for each site who was then responsible for overseeing survey completion. The profession or title of this primary point of contact for each pilot site is identified in the tables found within Appendix H.

Analysis of the activity statement responses indicates that the response rates for the Ambulance Service and Justice Health were high for all levels of these PHOs. At the facility and AHS levels of the Area Health Services this pattern was continued. At the clinical unit/department level of AHS however, there were significant differences between the

response rates according to the profession of primary point of contact. Response rates for activity statements emailed to NUMs was >90%. In contrast, the response rate was 31% for medical department heads. A number of reasons for these poor response rates were suggested by pilot sites during follow up, such as:

- the large volume of email correspondence sent to medical staff, where the importance of the QSA could be missed;
- the perception that hands on patient care is a priority over completing surveys such as the QSA; and
- the perception that systems and policies relating to patient safety and clinical quality were not the core business of medical staff.

Given these considerations, it may be appropriate to consider NUMs as the primary point of contact for completion of activity statements during the statewide roll-out. To ensure that activity statements are completed with the appropriate breadth of perspective, NUMs should also be provided with information on how to convene the multidisciplinary team for this purpose.

Burden and value of self assessment process

As part of the pilot process, respondents were asked to comment on the following aspects of the activity statement:

- The total time it took to complete the activity statements including the time taken to retrieve the information required to answer the questions and any consultation needed with other staff members;
- The value of each question in assessing activities, policies and processes relating to patient safety and clinical quality at their organisational level; and
- The burden of retrieving the information required to answer each question. As a guide, it was suggested that high burden questions were those that took more than a day to retrieve the data to answer, medium burden questions were those that required the

respondent to go to one other data source to get the data (time taken 30-60minutes) and low burden questions were those that the respondent was able to answer straight away without referral to another data source.

A summary of the time, burden and value of activity statement questions for the three major PHO categories is outlined in the tables below.

Area Health Services

	Unit	Facility	AHS
Time	60 minutes	28 hours (large facility with consultative method) 4 hours – small facility completed mainly by one person	30 - 32 hours Both AHS completed the pilot last year – this made the exercise quicker this time.
Burden	Most (> 75%) of questions were identified as low burden.	The burden of some facility questions were identified as significant however the perceived value on these questions by respondents was high	The majority of questions were low or medium burden. Those questions that were perceived as high burden were also identified as high value.
Value	High level of consensus that value was acceptable	High level of consensus that value was acceptable	High level of consensus that value was acceptable

Table 11: Feedback from pilot in AHS

Justice Health

	Clinic / Operational Unit	Stream	Area
Time	30-60 minutes	4-8 hours	2 days
Burden	Most questions identified as low burden	Burden was acceptable for those questions that were deemed relevant	Questions deemed low or medium burden.
Value	High level of consensus that value was acceptable although specialised services such as court liaison reported low value for questions relating to specific clinical risks	High level of consensus that value of most questions was acceptable. A number of questions were not relevant to stream functions	Value was acceptable

Table 12: Feedback from pilot in Justice Health

Ambulance Service

	Sector/Station	Division	State
Time	2 hours average	5-6 hours	20 hours
Burden	Most of the questions were identified as low burden.	The majority of questions were low or medium burden. Those questions that were perceived as high burden were also identified as high	The majority of questions were low or medium burden. Those questions that were perceived as high burden were also identified as

	Sector/Station	Division	State
		value.	high value.
Value	High level of consensus that value was acceptable	High level of consensus that value was acceptable	High level of consensus that value was acceptable

Table 13 Feedback from pilot in NSW Ambulance Service

Utility of the web based survey program

Generally there was wide acceptance of the use of a web based survey tool for collection of the assessment data. Some specific issues were raised that related to access to the internet for some professional groups, incorporation of a spell check function, accessibility of the data after completion of the assessment and for the longer surveys, locating particular questions and the time taken to progress through multiple web pages of questions.

Some recommendations that would increase the utility and acceptability of the program were developed as a result of the pilot. These include:

- providing an option to allocate and email a particular questions to a staff member to complete;
- use of hyperlinks or embedded objects to provide coaching or background material throughout the survey;
- a 'go to' function to enable direct access to a specific question;
- add a function that allows respondents to develop an action list against specific questions that is accessible after completion of the survey and is able to be updated on an ad hoc basis; and
- access to reports listing those who had completed the Activity Statements for AHS QSA coordinators.

Verification activities

As outlined in the methodology chapter of this report, a number of options for verification are available. As part of the pilot program, each of these methods were tested. Examples of how these methods were applied are outlined below. A sample of the verification activities undertaken can be found in Appendix E.

1. Same level verification

Example: NSW Ambulance Sector/Station

Question being verified	Question 20
Associated Question	Question 21
Number of responses	4 (of 5 sectors participating in the pilot)
Responses	Three respondents answered 'almost always'. One respondent answered 'almost never' Two of the three respondents who answered 'almost always' were able to identify through question 21 that this information was provided through a report from clinical development. One of these responses identified a number of specific data types that were provided. The other respondent identified that the report received was too voluminous to have much application at the sector/station level. The third respondent identified SAC 2,3 and 4 incidents as being something handled at the sector level
Verification judgment	The respondents who answered almost always and were able to identify the clinical development report as the source were likely to be providing an accurate answer to question 20 (the clinical development report if forwarded by divisions directly to sectors is likely to be big). The respondent who answered 'almost always' to question 20 may be correct but their answer is not verified through their response to question 21 as it did not identify

	the information/data provided through the report. The respondent who selected 'almost never' to question 20 did not (as appropriate) provide an answer to question 21.

Table 14. Example of same level verification activities NSW Ambulance

2. Between level verification

Example: NSW Ambulance Service - Division

Question being verified	Division question 24
Associated Question	Sector/Station question 16 Note: this is the same question asked at both levels: i.e. What processes are in place to ensure that Ambulance Staff have the skills and knowledge to response to a clinical incident (including but not limited to use of IIMS)
Number of responses	2 (to Division Question 24)
Responses to Associated questions in relevant sectors	one sector response for each divisional level response
Responses	Divisional Response 1: On-going training process at Divisional, Sector, Zone and Station levels. Associated sector level response: The general process will be that they seek guidance from the Duty District Officer. The wide variability in officer clinical and operational experience means that the skills and knowledge are not universal. District Officers have or no who has the required skills to manage the incident Divisional response 2: Number of staff have undertaken Safety Improvement Training and are actively involved in

	the RCA process. Clinical Incidents usually managed by the highest clinical level DO with advice and guidance from senior staff. Associated sector level response: Report to immediate supervisor, IMMS, Peer review (CTO), Seek clinical advice from Pt Safety Officer
Verification judgment	Divisional response 1: the sector level response does not verify the accuracy of the divisional level response. The appears to be a belief at the divisional level that there is a training process being undertaken at sector/station level. The response from sector/station level identifies more of an ad hoc approach with no formal process available and the quality of knowledge of those providing advice being variable. Divisional response 2: the response at the sector/station level provides some degree of verification to the divisional level response – that is, that incident management is generally escalated such that the most senior level of staff available are involved. However, the division level response also identifies safety improvement training being conducted and this element is not confirmed at the sector/station level.

Table 15: Example of between level verification activities NSW Ambulance

3. Source of evidence verification

Example: NSW Ambulance Service - State

Question being verified	Question 2
Response to question	yes

Response to request for source of evidence	Meetings held documented and archived every 4 months.
Verification	the source of evidence strongly verifies the accuracy of the response to the question being verified.

Table 16: Example of source of evidence verification activities NSW Ambulance

4. Desktop review verification

Example: NSW Ambulance Service - Division

Question being verified	Question 14
Response to question	Yes
Response to request for source of evidence	Discussion at Performance and risk Management Committee
Evidence provided on request	Extract Performance & Risk Management Committee Papers June 2007.
Verification judgment	There is clear evidence that performance is compared. The papers list each KPI and the performance of each division such that comparison is easily undertaken.

Table 17: Example of desktop review verification activities NSW Ambulance

5. Targeted interview verification

Targeted interview example – Justice Health

Question being verified	Question 10, 11, 12, 13

Response to question	Staff meeting. Includes discussion of clinical incidents, any procedural issues or issues that arise outside the scope of the CNC role
Response to request for source of evidence	Description of forums and activities undertaken during which patient safety and quality issues are discussed
Evidence provided on request	Detail of scheduled videoconferences including topics discussed, procedures and case studies. Regular attendees were listed
Verification judgment	Interview corroborated information provided. Also corroborated by other clinician within operational unit.

Consultation interviews regarding changes to activity statements

Consultation occurred at the completion of the piloting to inform the final changes to the wording of activity statements, content and the use of verification tools.

It was identified that the scope of the assessment should be expanded to include implementation of the National Inpatient Medication Chart (NIMC) and patient falls prevention. Additional questions to address this were incorporated into the final activity statements. In addition, the risk approach has enabled access to detailed information on falls and prevention activities where it was identified as an area of high risk.

Reporting

A critical element of the QSA is the reporting of findings of the assessment activities to relevant stakeholders. The rationale for the development of the QSA was to provide NSW Health with assurance about the quality of health services and assist the CEC in identifying areas for improvement and promotion of better practice in patient safety management. Analysis of the findings of the QSA and reporting these findings to all levels of the health system is key to achieving the objectives of the QSA.

Reporting to the NSW Health system will provide information on systems issues and identify strategies to improve patient safety & clinical quality systems. This may include identification of a need for specific initiatives, policy development or resourcing issues. The reports will identify areas for improvement and provide an assessment of standing against other organisations including stratification to allow a comparison within peer groups.

Reporting to the public will provide an assessment of the state of the safety and quality management systems of NSW Health organisations. Options for public reporting including the degree of detail and identification of organisations are issues that the CEC will be required to address in the future.

Reporting will occur at the following levels:

- a statewide report to the health system and the public;
- report to each PHO including eight Area Health Services, Justice Health and NSW Ambulance Service;
- report to each respondent at each level of the system:
    - Area Health Services – area, cluster/network, facility and clinical unit;
    - Justice Health – area, streams and clusters/operational units; and

- NSW Ambulance Service - state, divisions, sectors/stations.

The reports will provide the results of the self assessments, a discussion of findings of the verification activities, analysis of trends and a summary of the opportunities for improvement. It is anticipated the analysis will investigate issues such as:

- the variation between organisations, geographical location, facility types;
- other patterns of variation seen across the various assessment domains and/or topics;
- the level of compliance with policy elements; and
- degree of maturity of specific systems and processes.

Where there is significant variation between respondents or evidence of under performance an analysis will be undertaken to identify possible opportunities for improvement. These potential areas for improvement provide an opportunity for collaborative development with CEC, CGUs and NSW Health.

Report development

In developing the reports a comprehensive analysis of activity statement responses and verification findings is required. A quantitative analysis will be performance on all closed questions. Open questions will require thematic analysis and where possible categorization of responses. This process will also assist in refining the assessment tools and strengthening the quality of the data collected.

A series of steps will be undertaken to ensure that the assessment data and findings are robust. Respondents will be provided with an interim validation report and a final comparative report.

Validation report - An interim report of assessment will be provided to the respondents to allow the PHO/AHS/Facility/Unit to validate data. Respondents will be provided with an opportunity to modify any responses that appear incorrect on the validation report.

Comparative report – A final report will be provided to all respondents and will provide feedback on performance together with collated data from other AHS/facilities/units/clusters/streams/divisions/stations. Comparative analysis is possible on all closed questions and this will be provided in graphical format. Open questions will be themed and a descriptive report of all responses provided. Where possible these will be grouped and quantified. Reporting will allow comparison against other organisations or units, stratified for peer group. Where appropriate an analysis of individual factors using statistical techniques will be used to provide meaningful comparison and address issues of relative risk.

Report structure

The structure of the reports will provide a systematic view of each of the domains and subset of topics which are assessed. The grouping of domains and topics including the related questions at each assessment level are outlined in Appendix I.

An overview of results will provide information on emerging themes and trends, key issues identified and opportunities for improvement. A proposed common structure for reports to each level of the system is outlined below. The

- Introduction including a message from the CEO of the CEC
- Table of contents
- About the QSA – background and methodology
- An overview of results for the entity which is the subject of the report
    - Themes
    - Key issues
    - Opportunities for improvement
- Detail of results by domain and topic including:
    - Analysis of trends

- Opportunities for improvement

Reporting formats

Reporting formats should be appropriate for the audience for whom they are intended and as such a range of reporting formats could be utilised to ensure widespread dissemination of findings of the assessment as well as facilitating improvement activities. Expanding the functionality of the web based application used to lodge self assessments to include access to amalgamated performance reports will enhance the value of the process particularly to AHSs where a large number of units will be assessed.

Costing

Overview

Outlined below is a summary of the indicative costs of the implementation and ongoing management of the QSA. Both the costs to the CEC and to PHOs have been considered. The estimates are based on the following elements:

1 management and coordination of the QSA program by the CEC;

2 training for PHOs;

3 QSA database development (one-off);

4 ongoing database management and support; and

5 annual data analysis and performance reporting.

An examination of the time taken by different levels of PHOs to complete the activity statements during the QSA pilot has also been undertaken. While it is recognised that there is an additional 'burden' on PHOs to complete the QSA, the extent of this additional burden is acceptable given it complements existing quality and safety effort, and will be accommodated within existing staff resources. For this reason, it is considered that there will be no additional costs borne by PHOs in fulfilling the requirements of the QSA.

The following table summarises the major costs associated with the QSA.

$m	Year 1	Year 2	Year 3	Year 4	Year 5	Total
CEC costs:						
QSA program management and coordination	0.415	0.222	0.222	0.222	0.222	**1.080**
Training for verification	0.157	0.025	0.025	0.025	0.025	**0.232**
Database development	0.100	0	0	0	0	**0.100**
Ongoing database management and support	0.137	0.137	0.137	0.137	0.137	**0.550**
Annual data analysis and reporting	0.150	0.150	0.150	0.150	0.150	**0.600**
Total – CEC	*0.960*	*0.534*	*0.534*	*0.534*	*0.534*	***2.562***
PHO costs						
QSA implementation	0	0	0	0	0	**0**
Total – PHOs	*0*	*0*	*0*	*0*	*0*	***0***
Total – QSA	**0.960**	**0.534**	**0.534**	**0.534**	**0.534**	**2.562**

Table 18: Summary of indicative costs – QSA implementation and management

Costing approach

The indicative costs outlined in this section are based on estimates of staff and other costs for each element of the QSA implementation and ongoing management. Staff costs are based on estimates of full-time equivalents, NSW Health Awards, salary on-costs and estimates of additional costs associated with employing additional staff. Non-staff costs are based on cost estimates for each element.

Indicative costs have been estimated for each of the next five years.

Indicative costs are based on the additional cost of establishing and providing each of the elements associated with QSA implementation and ongoing management, rather than the total cost, and consideration has been given to the degree to which QSA activity can be met from within existing CEC and PHO resources. As such, the indicative costs outlined in this report represent the approximate additional funding required to implement and manage the QSA on an ongoing basis. It should be noted however, that these estimates are indicative, and should be further examined and considered by the CEC prior to any budget proposal being put forward.

Program management and coordination

Description

The management and coordination of the QSA program will be undertaken by the CEC, and will involve oversight of the implementation of the QSA in the first year, and the following management and coordination activities on an ongoing basis:

- providing strategic oversight;
- providing direction and support to PHOs;
- articulating QSA requirements and timelines;
- monitoring the outcomes from the program and recommending improvements over time; and
- managing external contracts, e.g. for annual performance analysis and reporting.

Indicative costs and underlying assumptions

The indicative costs for this component are based on the following staff establishment:

- a program coordinator (1 FTE in year 1, 0.5 FTE ongoing), employed at Health Service Manager level 5 under the Health Services Manager Award;

- a project officer(s) (2 FTEs in year 1, 1 FTE ongoing), employed at Health Service Manager level 3 under the Health Services Manager Award; and

- an administrative assistance (0.5 FTE), employed at Administration officer level 3 under the Health Employees Administrative Staff Award.

Staff costs include provision for salary on-costs of 16.3 per cent which include: superannuation guarantee contribution (9%), annual leave loading (1.3%), and payroll tax (6%).[3] Indirect employment costs are also included to cover the cost of training, IT costs, and HR and other administration for additional staff, and have been estimated to be approximately 10 per cent of base salary.

No provision has been made for indexation or award increases.

In addition to staff-related costs, provision has also been made for the cost of travel by CEC staff to PHOs to assist in the implementation of the program and to provide support to PHO staff on an ongoing basis.

Indicative costs are outlined in Table ** below

	Year 1	Year 2	Year 3	Year 4	Year 5
Staffing costs					
Coordinator	$152,517	$76,259	$76,259	$76,259	$76,259
Project officer	$234,956	$117,478	$117,478	$117,478	$117,478
Administration	$27,788	$27,788	$27,788	$27,788	$27,788
Total staffing costs	*$415,261*	*$221,524*	*$221,524*	*$221,524*	*$221,524*
Other costs					
Travel	$30,000	$20,000	$20,000	$20,000	$20,000
Total	**$415,261**	**$221,524**	**$221,524**	**$221,524**	**$221,524**

Table 19: Indicative costs for QSA program management and coordination

[3] No provision has been made for workers compensation premiums, given premiums in NSW are only partly dependent on the number of employees. No provision has been made for long service leave, given the small cost of such leave and the uncertainties regarding the cost for individual employees.

PHO support and training

Description

This component relates to the provision of training in verification activities, and where required the provision of specific training and support to the different PHO levels during the first year of implementation of the QSA.

It has been assumed that there will be a need for dedicated training staff in year one of the program only, that is, during initial implementation, and that there will be a need for one full-time trainer (or two full-time equivalent trainers for the first six months) to assist with implementation. It has been assumed that ongoing support after year one will be provided by the program coordinator and project officer (see previous component).

Indicative costs and underlying assumptions

The indicative costs for this component are based on the following:

- a full-time trainer or two full-time equivalent trainers for six months (1 FTE in total) in year 1 only employed at Health Service Manager level 3 under the Health Services Manager Award, with salary on-costs of 16.3 per cent of base salary (as outlined in the previous section), and indirect employment costs of 10 per cent of base salary;

- $10,000 per annum ongoing for the development and provision of training materials and to cover training related costs; and

- $30,000 in year 1 and $15,000 per annum ongoing to cover travel costs relating to training (that is, trainers or program coordinator/project officers travelling across the State to provide training)

As for other components, no provision has been made for indexation or award increases.

Indicative costs are outlined in Table 20 below.

	Year 1	Year 2	Year 3	Year 4	Year 5
Staffing costs					
Trainer (2 x 0.5 FTEs - year 1)	$117,478	$0	$0	$0	$0
Total staffing costs	*$117,478*	*$0*	*$0*	*$0*	*$0*
Other costs					
Training materials	$10,000	$10,000	$10,000	$10,000	$10,000
Travel	$30,000	$15,000	$15,000	$15,000	$15,000
Total other costs	*$30,000*	*$15,000*	*$15,000*	*$15,000*	*$15,000*
Total	**$157,478**	**$25,000**	**$25,000**	**$25,000**	**$25,000**

Table 20: Indicative costs for PHO support and training

Database development

Description

This component relates to the development of software necessary to collect QSA data from PHOs, and to develop a central CEC-managed database to store this data.

It is envisaged that initially, the database and associated software will be relatively simple and be based on software applications already in the marketplace (such as Microsoft Access). In future years, as the amount of data collected increases and the QSA develops (which may result in more sophisticated data being collected), that additional investment will be necessary in development of the database.

Indicative costs and underlying assumptions

The indicative costs for this component are based on an estimate of

- software costs; and
- time taken for database development by an external provider.

Indicative costs are outlined in Table 21 below

	Year 1	Year 2	Year 3	Year 4	Year 5
Staffing costs	$0	$0	$0	$0	$0
Database development - external	$100,000	$0	$0	$0	$0
Total	**$100,000**	**$0**	**$0**	**$0**	**$0**

Table 21: Indicative costs for database development

Database management and support

Description

This component relates to the management of the web based survey tools, QSA database, provision of IT- and data-related support in relation to QSA data returns, and extraction and reporting of data in an ongoing basis to the program coordinator.

Indicative costs and underlying assumptions

The indicative costs for this component are based on the following:

- a database manager (1 FTE), employed at Health Service Manager level 3 under the Health Services Manager Award, , with salary on-costs of 16.3 per cent of base salary and indirect employment costs of 10 per cent of base salary; and
- $20,000 per annum for ongoing updating the web survey tools, IT-related expenses for the maintenance of the database, IT infrastructure, and associated costs.

As for other components, no provision has been made for indexation or award increases.

Indicative costs are outlined in Table 22 below.

	Year 1	Year 2	Year 3	Year 4	Year 5
Staffing costs					
Database manager	$117,478	$117,478	$117,478	$117,478	$117,478
Total staffing costs	*$117,478*	*$117,478*	*$117,478*	*$117,478*	*$117,478*
Other costs	*$20,000*	*$20,000*	*$20,000*	*$20,000*	*$20,000*
Total	**$137,478**	**$137,478**	**$137,478**	**$137,478**	**$137,478**

Table 22: Indicative costs for database management and support

Performance reporting and analysis

Description

This component relates to the annual reporting component of the QSA, where performance data reported by PHOs is collated, analysed and reported, together with key achievements and progress made in relation to quality and safety in the NSW public health system.

It has been assumed that this annual performance analysis and reporting process will be undertaken by an external organisation under contract with the CEC, with contract management, oversight and direction provided by the QSA program coordinator.

Indicative costs and underlying assumptions

The indicative costs for this component are based on the following estimates of the cost of qualitative analysis of assessment results including thematic analysis of open questions and interpretive analysis of closed questions. In interpreting the costing for this component it should be noted that an accurate estimate of the time involved and therefore the cost is not possible until the number of entities to be assessed is known.

As for other components, no provision has been made for indexation or award increases.

Indicative costs are outlined in table 23 below.

	Year 1	Year 2	Year 3	Year 4	Year 5
Staffing costs	$0	$0	$0	$0	$0
External contract fees	$150,000	$150,000	$150,000	$150,000	$150,000
Total	**$150,000**	**$150,000**	**$150,000**	**$150,000**	**$150,000**

Table 23: Indicative costs for performance reporting and analysis

Costs to Public Health Organisations

Description

An analysis of the time taken by PHOs to conduct the quality and safety assessments required by the QSA on an annual basis has been undertaken, based on data gathered during the pilot stage of the QSA. This analysis occurred at each level of the three PHO types (subject to the data received by pilot participants).

It is recognised that there is an additional 'burden' on PHOs to complete the requirements of the QSA. However, the extent of this additional burden is acceptable given that it complements existing quality and safety efforts, and the pilot program has demonstrated that PHOs can accommodate the requirements of the QSA within existing staff resources. For this reason, it is considered that there will be no additional costs borne by PHOs in fulfilling the requirements of the QSA. Instead, the time burden is outlined in the tables below.

When examining the cost components, it should be recognised that ideally, activity statements are completed by a lead coordinator, and advised by multidisciplinary input. For example, at the clinical unit level in AHS, the NUM may coordinate the response, but seek input from medical, other nursing and if applicable, allied health staff. Similarly, at the facility and AHS levels, the Quality Manager may complete the activity statement, and as necessary, coordinate relevant input from other areas of the organisation such as general management or clinical

operations. Similar multidisciplinary models should be used across other PHO types.

It should be noted that the facility level activity statement may be associated with a highly variable time burden, as this particular activity statement may be completed by facilities of a diverse size. Pilot results indicate the time taken for a small facility (e.g. 80 beds) is considerably less than that taken for a larger facility (e.g. 400 beds) to complete the activity statement. As such, time burdens in the tables below are prefaced with the words 'up to', and the upper estimate of time burden indicated.

Area Health Services

Level/ *Staff type*	**Hours pa**
Clinical unit level	
Nurse unit manager	1
VMO/ Staff Specialist	0.5
General Nursing staff member	0.5
Allied Health or similar	0.5
Total – per clinical unit	*2.5 hours*
Facility level	
Quality Manager	15.0 hours
Hospital executives/ Managers (Various areas)	Up to 10.0 hours
Total – per facility	*Up to 25.0 hours*
AHS level	
Area Manager – Quality & Safety	15.0 hours
AHS executives/ managers (various areas)	Up to 15.0 hours
Total – per AHS	*Up to 30.0 hours*

Table 24: Estimated annual time burden per annum for activity statement completion by Area Health Services

Justice Health

Level/ *Staff type*	Hours pa
Clinic/ Operational unit level	
Nurse manager/ Unit manager	1.0
Clinic nurses	4 x 0.25
Total – per clinical unit	*2.0*
Stream level	
Stream manager	5.0
Other Managers (Various areas as appropriate)	4 x 0.25
Total – per Stream	*5.0*
Area level	
Quality & Safety Manager	20
Area executives/ managers (various areas)	5 x 1.0
Total – Area	*25*

Table 25: Estimated annual time burden per annum for activity statement completion by Justice Health

NSW Ambulance Service

Level/ *Staff type*	Hours pa
Sector/Station level	
Sector manager	1.5
Station manager	0.25
Station Manager	0.25
Total – per Sector/Station	*2.0 hours*
Division level	
Divisional Manager	3 hours
Other Managers (Various areas as required)	6 x 0.5 hours
Total – per Division	*6.0 hours*
State level	

Level/ *Staff type*	Hours pa
Patient Safety Manager	15.0 hours
Other managers (various areas as required)	5 x 1.0 hours
Total – State	*20.0 hours*

Table 26: Estimated annual time burden per annum for activity statement completion by NSW Ambulance Service

Considerations moving forward

The next step for the CEC will involve rolling out the QSA to all levels of the NSW Health system. In doing so, there are a number of issues for consideration.

- **The need to address the culture of blame and fear.** While there are pockets of clinical practice where staff enjoy a blame free environment, many parts of the health system still report that a culture of blame is prevalent. Addressing cultural change will be an ongoing challenge for the CEC as the QSA is implemented. It will be critical for CEC to work to ensure that the improvement focus of the QSA is a strong message which accompanies all activities.

- **The current lack of policy to support some of the NSW Health Patient Safety and Quality Standards**. Without a strong evidence base or policy framework underpinning a number of the Standards, identifying and promoting good practice in these areas is difficult. It will be critical to identify good practice and build the evidence base, both through examining the literature, and through the retrieval of information through activity statements and verification activities.

- **The need for clarity and leadership around ongoing support activities**. For the QSA to succeed in its mission, ongoing support will be required to ensure that the QSA's role remains as one of an improvement tool. Ongoing support needs for PHOs may include the development of policies or guidelines or the provision of advice around specific safety and quality issues faced by health services. It will be important to clarify roles around governing bodies such as the CEC, NSW Health and AHS in relation to who is responsible for providing each of these support needs so that a coherent and comprehensive approach is achieved.

- **System engagement and marketing to clinicians and managers.** While the pilot program demonstrated it is possible for the QSA to be accepted by both managers and clinicians, its wider support will require careful, consistent and clear marketing to its users. Strategies such as gaining consensus on the key messages

prior to roll out, seeking and responding to feedback in a timely manner, and identifying and recruiting the support of key safety and quality leaders in each PHO will be critical to the success of gaining acceptance of the QSA throughout the system.

- **Informed dialogue with consumers**. Involvement of consumers in shaping changes to health service provision is critical to ensuring that services are aligned to the communities and populations that they serve. Informing the public of the findings of the QSA is important to build confidence and support in ongoing improvement activities. Further consultations with consumer representatives and NSW Health by the CEC will assist to identify optimal methods and formats for reporting and socialisation of QSA findings to the public.

- **Governance and strategic alignment**. The QSA needs to maintain its relevance to the system and ensure that the content of the assessment aligns with identified risks and key areas of strategic focus within the NSW health system. An ongoing governance group with key stakeholder representation is required to oversee the ongoing program of work, identification of targeted areas for assessment and oversight of reporting and communications.

Appendix A

The following section summarises the major items identified through the literature review.

Discussion Paper – National Safety and Quality Accreditation Standards, Australian Commission on Safety and Quality in Healthcare (ACSQH), November 2006.

This paper was prepared by the Australian Commission on Safety and Quality in Healthcare (ACSQH) as a basis for consultation regarding the development of recommendations for a new model of accreditation and Standards for health services in Australia. The Discussion Paper poses a number of questions about standards & accreditation and seeks comments in response. It includes a package of proposals for a new approach to accreditation to stimulate debate on the topic and suggestions for improvement.

Standards

ACSQH identify that standards are developed both to protect the public from harm and to improve the quality of service provision. This discussion paper identifies 23 Standards setting bodies within Australia that are applicable to health care, and a corresponding 22 Accrediting bodies. Some of the Standards setting bodies have up to eight organisations involved in accreditation of the service/organisation. This will inevitably, involve up to eight different methods of accreditation.

Issues identified with mapping health care standards has shown that the complexity of this task is a direct result of the differences in terminology between sets of standards, variance of structure, style, and purpose of the standards. The Commission acknowledges that due to this complexity it is not possible at this stage to identify the extent of duplication in standards, nor the gaps in safety and quality standards that may exist. Further, there are issues around the proliferation of standards, access to standards, the process of developing standards and the appropriateness of their use in assessment.

Accreditation

The Discussion paper also identifies several issues around accreditation. These include:

- Effectiveness in identifying poor performance;
- Transparency;
- Governance;
- Duplication and Overlap;
- Resource requirements;
- Surveyors; and
- Information to support accreditation.

Proposed Reforms

The Commission proposes an integrated package of reforms to be applied nationally across all sectors in the health care system. The primary focus of these reforms is to avoid overlap and duplication between the Standards and Accreditation processes for health care services, including education and training programs.

The Commission outline 11 reform strategies to address the issues with Standards and Accreditation in Australian health care services. These reforms include:

- developing a register of accrediting bodies
- standardising accreditation language and definitions
- training and competency testing of surveyors
- better use if data for evaluation of health service performance
- system-wide accreditation against safety and quality standards
- introduction of unannounced surveys
- introduction of Tracer methodology in external accreditation reviews

- registration of sets of health care standards
- harmonisation of health service standards
- detailed mapping of standards
- identification of core safety and quality areas.

A copy of the Commission's discussion paper can be found at: http://www.safetyandquality.org/internet/safety/publishing.nsf/Content/whats-new-lp

10 Patient Safety Tips for Hospitals, Agency for Healthcare Research and Quality (AHRQ), February 2007.

This research provides organisations with some helpful hints to improve patient safety and make suggestions as to what protocols have had an impact in similar organisations.

The Agency for Healthcare Research and Quality (AHRQ) has funded more than 100 patient safety projects since 2001. Of these 100 pieces of research according to the AHRQ, ten practical tips can be put into practice in hospitals. These are summarised in the table below:

Practical Tips	Explanation
1 Assess and improve your patient safety culture	The use of staff surveys to assess patient safety and culture using tools developed by the AHRQ. http://www.ahrq.gov/qual/hospculture/
2 Build teamwork	The use of AHRQ toolkits established from evidence-based training techniques for effective communication to improve teamwork within the organisation.
3 Limit shifts for hospital staff	Minimise shifts of more than 16 hours for all health professionals. Studies of two hospitals in the United States showed that eliminating 30-hour shifts by medical staff

Practical Tips	Explanation
	decreased the number of accidents and injuries.
4 Insert chest tubes safely	The introduction of an easy-to-remember mnemonic (UWET) regarding insertion of chest tubing from a universal protocol developed by the Joint Commission.
5 Prevent central line-related bloodstream infections	Utilising five evidence –based procedures to prevent infections such as these led to a reduction of deadly infections to zero in a study of more than 100 hospitals.
6 Make good use of senior ICU nurses	A study concluded that shifts with the appropriate senior staff cover within ICU led to fewer airway tube complications when they were present than when junior staff were left in the Department.
7 Use reliable decision-support tools at the point of care	"Computerised physician order entry or personal digital assistant-based drug information is available at the point of prescribing of ordering" reduces the potential errors associated with insufficient or incomplete drug information.
8 Set up a safety reporting system	Example of a web-based reporting system in the ICU to help eliminate system failures that lead to errors in healthcare. This aids comparison of near misses to adverse events and examine providers perceptions of the reporting systems.
9 Limit urinary catheter use to 3 days	Introduction of best practice by assessing catheter use within 3 days of insertion and setting up methods to remind clinicians to review and remove as soon as possible to minimise urinary tract infections.

Practical Tips	Explanation
10 Minimise unnecessary interruptions	Reduce distractions faced by nursing staff especially when changing shifts. Empower nurses to inform the person interrupting that it is not appropriate to do so at this time. This will reduce errors especially when conducting handover or administering medications.

Table 27: 10 Patient safety tips for hospitals

A copy of the AHRQ's patient safety tips for hospitals can be found at: http://www.ahrq.gov/qual/10tips.pdf

State of Healthcare 2006, Healthcare Commission UK, October 2006.

The Healthcare Commission in the UK is an independent body responsible for reviewing the quality of healthcare and public health in England, with a smaller role in Wales. Part of the Healthcare Commission's role is to assess the performance of healthcare organisations in England, including both the private and public sector.

The performance of the health system is reported through a system called the annual health check. Previously, NHS trusts were provided with a gold star rating, in order to rate their performance. The 2005/6 however, a new health check system was used to provide their annual rating of performance. The information used to develop this rating comes from a range of sources, including both data from the Trust themselves, as well as from other sources, such as the Commission for Social Care Inspection and the Mental Health Act Commission.

The rating given to Trusts has two components:

1. Quality of services available to patients and the public; and

2. Management of finances and other resources[4].

[4] State of Healthcare 2006, Healthcare Commission October 2006 p.7

In relation to scoring the quality of service, trusts are assessed against a range of elements. These elements include core standards, national standards, and new national standards. Against each of these standards, trusts are assigned a four point score, which are combined to give them an overall rating for each element. Consideration is also given to independent reviews taken throughout the year, which investigate a specific focus area, such as diagnostic services, or services for children. These reviews also result in the assignment of a rating based on a four point scale. Rules are then used to aggregate the scores a trust received for each element into a total rating for the trust for quality of service. These ratings are again assigned on a four point scale as either weak, fair, good or excellent.

The process used to undertake the health check is based on self assessment. All Trusts submit their self assessment of their compliance against a set of core standards. These self assessments are then verified through inspection of approximately 20% of Trusts. This inspection occurs either randomly or through a risk based process. Approximately half the inspections were targeted in trusts where it was thought there was the greatest risk of a failure being undeclared. During the inspection process, each trust's self assessment is cross checked against a broad range of information, including from national sources, from information provided by other regulators and bodies, and from the Commission's own intelligence.

To follow up on the results of this assessment program, the bottom 10% of trusts are provided with support in order to assist them in improving their performance.

More information about the Healthcare Commission's Annual Health Check process can be found at:
http://annualhealthcheckratings.healthcarecommission.org.uk/annualhealthcheckratings/abouttheannualhealthcheck.cfm

Public reporting of hospital outcomes based on administrative data: Risks and Opportunities, The Medical Journal of Australia (MJA) 2006; 1854(11): 571-575.

This article counters recommendations made in the Forster inquiry that routinely collected administrative data should be publicly reported to inform the public and promote change in practices by hospital staff.

The authors suggest that while public reporting is worthwhile, it needs to be carefully presented to ensure reports are interpreted accurately.

A number of issues with the public reporting of hospital data are identified and discussed. These include:

- The validity of hospital reports – as a result of issues such as inaccurate/incomplete/insufficient data, failure of analyses to control adequately for differences (e.g. casemix), and difficulties in minimising the effects of random error. Further, the authors question whether differences in outcomes based on administrative data reflect real differences in quality of care, and whether true variation in outcome can be reliably detected for hospitals that are similar.

- Whether the lay public can access, interpret and appropriately act on hospital reports

- The possibility that public reporting provides health services with perverse incentives around care and its quality (e.g. avoidance of high risk patients, inappropriate early discharge, or concentrating efforts on those areas that are performance managed and ignoring those that are not)

This article can be viewed at:
http://www.mja.com.au/public/issues/184_11_050606/sco10085_fm.html

Ready, Set, Survey- Is your facility Prepared for Tracer Methodology? Brenda L. Johnson and Valerie R. Davis (For the Record vol 16 No. 21 Pg 18).

This article discusses a different model of assessing and accrediting an organisation – that of a process which "traces" the patient journey – from point of entry to post discharge and at all points in between. The process is termed "tracer methodology" and has been introduced in America for the former Joint Commission on Accreditation of

Healthcare Organisations (JCAHO) to conduct their accreditation processes.

The article acknowledges that sometimes organisations are so used to being assessed that they ensure that they are what Johnson and Davis refer to as "survey ready". Through the use of the tracer methodology, the review team spend more time with patients mapping and exploring their experience of the service, rather than reviewing documentation. This process has been adopted by JCAHO for their accreditation.

Tracer evaluations begin with the surveyors selecting an active patient or recently discharged patient and using that individuals medical notes as a 'road map' to move through the organisation to "assess and evaluate the facility's compliance with selected standards and systems of providing care and services"5. Surveyors assess patient care and safety by interviewing the staff in areas that provide the service for the individual. The team follows the patient's treatment path and assesses compliance with Standards. Systems are reviewed for their delivery of safe, quality healthcare.

Surveyors focus on system-level issues within the organisation that arise from tracing individual patients. If appropriate, the surveyors may still ask for permission to speak to a patient.

This methodology requires a healthcare organisation to work as a team as opposed to preparing one particular area for a survey that is independent of the rest of the organisation. This process assesses the interface between departments and assesses the documentation to protect the patient's safety when care is transferred from one provider to another.

Clinicians also find the process meaningful because it looks at the service from the perspective of the patient.

This article can be viewed at:

http://www.fortherecordmag.com/archives/ftr_101804p18.shtml

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[5] ibid

Internal Control over Financial Reporting-Guidance for Smaller Public Companies (Committee of Sponsoring Organizations of the Treadway Commission (COSO) 2006).

This document is focussed upon the financial health of an organisation and the issues associated with reporting financial outcomes. Accompanying this document is an Integrated Framework which was developed by the Committee of Sponsoring Organizations of the Treadway Commission (COSO) in 1992. This Framework has been recognised by executives, board members, regulators, standards setters, professional organisations and others as an appropriate comprehensive Framework for internal control.[6]

This document provides guidance as to how to apply the Framework. The aim is to use the Framework to design and implement cost-effective internal control over financial reporting.

One of the central themes portrayed in this document is the requirement for appropriate financial reporting objectives. It suggests that appropriate financial reporting objectives result in more effective business activities and subsequently these are reflected in appropriate financial statements and accounts.

Documentation of business processes and procedures is an essential element in tracking the performance of the organisation. This document suggests that effective documentation assists in communicating what is to be done, and how, and creates expectations of performance. Documented business processes and procedures can also be used as a tool for reference and to assist in the training of personnel. Importantly, it also provides evidence which may be used for the process of accreditation or evaluation. The bigger an organisation is, the more important documentation becomes as there is not the intimate knowledge of every single aspect or individual responsibility for the entire process. Instead the process has many stages, and many people can input along this process.

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[6] Internal Control over Financial Reporting – Guidance for Smaller Public Companies, Volume 1: Executive Summary June 2006 p.1.

COSO recognises that there may be instances where policies and procedure are informal and not documented. Nevertheless, managers should be able to evidence the use of these policies through other means.

There are five key components of the Framework, which outline 20 basic principles, these are briefly outlined in the following table:

Component	Principle[7]
Control environment	Integrity and ethical values; Understanding and responsibility relating to financial reporting and internal control by Board of Directors; Management philosophy and style; Organisational structure; Financial Reporting Competencies; Management and employees are assigned appropriate levels of authority and responsibility; and Effective human resources policies to support financial reporting.
Risk Assessment	Clarity of objectives; Identification of risks; and Appropriate management of risks.
Control Activities	Integration with risk assessment; Development of control activities to mitigate risks; Policies and procedures to support reliable financial

[7] Adapted from Internal Control over Financial Reporting – Guidance for Smaller Public Companies, Volume 1: Executive Summary June 2006 p.11.

Component	Principle[7]
	reporting; and Information technology to support the achievement of financial reporting objectives.
Information and Communication	Pertinent information is gathered to support the achievement of the financial reporting objectives; and Internal and External communication of the financial reporting objectives.
Monitoring	Evaluations; and Reporting deficiencies.

More information about these financial reporting controls can be found at:

http://www.coso.org/publications.htm

The regulation of health and safety in the Australia Offshore petroleum Industry (1996 Barrell Report). Dr Tony Barrrell, 1996.

This report outlines the findings of a review of safety management in the Australian offshore oil and gas operations. The review was requested by the Commonwealth Government as part of a larger review process undertaken to assess the findings from a UK inquiry into the UK Piper Alpha petroleum platform disaster in the North Sea and determine their applicability to offshore safety in Australia.

Current thinking in relation to safety regulation in offshore operations is based on four main principles:

1 That employers who create risks to their employees by practising their business activities are wholly responsible for controlling and reducing those risks

2 That the regulator is responsible for administering the safety legislation and where necessary enforcing it

3 That the legislation should be objective based, in that it sets out the safety goals to be achieved, but does not prescribe the solutions

4 That the approach to safety improvement should be risk abased, in other words all risks should be identified and assessed and the action taken to reduce the risks should then be proportionate to the size of those risks

Principles 1 and 2 combined can be referred to as 'self regulation' or 'coregulation'. The process of self-regulation is most effective when there is a good relationship between the industry and the regulator.

To provide clarity in relation to the standards to be achieved, it is necessary to have non-mandatory guidance, with examples of good practice. It should explain that while the guidance sets out safety measures that represent good practice, any other alternative which can be shown to achieve the same (or better) standards is equally acceptable.

The regulatory function of safety should be removed from the UK government (Department of Energy) such that regulation does not become intertwined with the function of petroleum promotion.

It is vital that those who assess the performance of operators have adequate skills in critical analysis to effectively undertake this role.

When new projects and processes are under design, operators should consider their own past experience and how this should be reflected in ensuring safety in the new design.

This report can be viewed at:

http://www.nml.csiro.au/content/itrinternet/cmscontent.cfm?objectid=3CF31084-5A0A-4559-AB7E44560DEC2A9D&indexPages=/content/sitemap.cfm?objectid=48A6218E-20E0-68D8-ED51153BC4D59BE5

Appendix B

Members of the QSA Development Team included:

Cliff Hughes: CEO Clinical Excellence Commission

Bernie Harrison: Director Quality Systems Assessment, CEC

Bruce Barraclough: Chairman, CEC Board

Kathy Baker: Member, CEC Board

Michael Smith: Director, Quality and Safety Branch, NSW Health

Barbara Rodham: Director, Quality and Safety Branch, NSW Health

Sue-Anne Redmond: Director Clinical Governance, GWAHS

Matthew Daly: Director, Clinical Operations, SESIAHS

Charles Pain: Director Clinical Governance SWAHS

Paul Tridgell: Australian Council for Safety and Quality in Health (ACSQH)

Liz Forsyth: KPMG

Louise Kershaw: KPMG

Kate Hawkins: KPMG

Appendix C

Experts contacted for individual interviews

This table identifies the list of individuals with whom interviews were completed as part of the consultation process.

Name	Title
Chris Borton	VMO Anaesthetics Royal Prince Alfred Hospital
Jeffrey Braithwaite	Director of the Centre for Clinical Governance Research in Health University of NSW
Peter Castaldi	Professor of Medicine Westmead Hospital
Jeremy Chapman	Clinical Stream Director of Renal, Urology and Transplantation Services Western Sydney AHS.
Rohan Hammett	Consultant Gastroenterologist Royal North Shore Hospital
Ken Hillman	Professor Of Intensive Care Liverpool Health Service
Philip Hoyle	Director of Clinical Governance NSCCAHS
Wendy Jamieson	Area Quality manager SSWAHS
Betty Johnson	Consumer Advocate
Miles Little	Professor of Surgery University of Sydney
Heather McDonald	ACHS
Ron Penney	Senior Clinical Advisor Intergovernmental and Funding Strategies NSW Health
George Rubin	Director, Centre for Health Services Research

	Westmead Hospital
Gary Sly	NSW Health
Alison Turner	General Manager National Blood Authority
Martin Van Der Weyden	Editor Medical Journal of Australia
Merrilyn Walton	A/Professor of Ethical Practice, Faculty of Medicine Sydney University
Ross Wilson	Director Northern Centre for Healthcare Improvement Royal North Shore Hospital
Alan Wolff	Director of Medical Services Wimmera Health Service

Appendix D

Roles and Responsibilities documents for:

- Area Health Services
- Justice Health
- NSW Ambulance Service

This document is attached separate to the report

Appendix E

Additional Examples of how Verification methods might be applied

Same level verification

Example 1

Level	Unit
Question being verified	2 – How are safety and quality issues or clinical risks identified (*respondent chooses from list provided)*
Associated Question	14b) – IMMS is used to enter data on clinical incidents (*respondent chooses frequency from list provided)*
How the verification is applied	If the response to question2 indicates that risks are identified through the review of incidents or IIMS data, then the response to question 14b) should indicate that IIMS is in fact used to enter data on clinical incidents. If the respondent answered rarely, almost never of NA for 14b) it is possible that the answer to question 2 is inaccurate and that IIMS data is not how risks are identified.

Example 2

Level	Facility
Question being verified	8 – Does the facility compare its performance on safety and quality indicators with other facilities? (*respondent chooses from list provided)*
Associated Question	9 – How do you compare performance on clinical indicators? (*open response in text box)*
How the verification is applied	If the response to question 8 is that the facility does compare performance then they should be able to identify how performance is compared in their response to question 9. If they are unable to answer question 9, then the

	response to question 8 may be inaccurate.

Example 3

Level	Facility
Question being verified	18 – Does the facility use information about clinical risks to prioritise patient safety and quality improvement project initiatives within the facility? (*yes/no/NA options)*
Associated Question	19 – How does the facility prioritise patient safety and quality improvement projects? (*open ended with text box)*
How the verification is applied	If the response to question 18 is yes, then the respondent should also be able to provide an answer to question 19. Inability to answer question 19 would indicate that the response to question 18 is incorrect.

Example 4

Level	AHS
Question being verified	47 – Is complaints data analysed by the AHS to identify trends or clusters of complaints? (*yes/no options)*
Associated Question	48 – How is complaints data analysed? (*text box available for response)*
How the verification is applied	If the response to question 47 is yes then the respondent should also be able to provide an answer to question 48. Inability to answer question 48 would indicate that the response to question 47 is incorrect.

Between level verification

Question being verified	AHS 29 – How is information on analysis of clinical incidents, RCAs and recommendations provided to the groups listed in the questions above? (*question above identifies groups as (AHS advisory council, chief exec, facility management, & inical unit managers)*

Associated Question	Facility 28 – Does the facility receive information regarding the outcomes and recommendations of RCA analysis? (*yes/no options)*
How the verification is applied	If the AHS provides a description of how it provides information to the facilities then the responses from the facilities within this AHS should indicate that they receive this information. For example, if 80% of facilities say they receive the information then the AHS is accurate in saying that they have a process which provides it. If only 20% of facilities say they receive this information however, then the AHS's response that they provide the information to facilities is inaccurate.

Example 3

Question being verified	Facility 34a) – When a SAC1 or SAC 2 incident occurs a senior clinician involved in the care of the patient acknowledges the incident to the patient or their support person/carer (*section frequency from set options)*
Associated Question	Unit 15a) - When a SAC1 or SAC 2 incident occurs a senior clinician involved in the care of the patient acknowledges the incident to the patient or their support person/carer (*section frequency from set options)*
How the verification is applied	The response chosen by the facility for 34 a) should correlate with the majority of the responses from units to question 15a). That is, if the facility identifies that the incident is acknowledged by a senior clinician 'almost always', then most of the units within that facility should also indicate that this occurs 'almost always' or at least 'often'. If the majority of the units identify that this happens only 'sometimes', 'rarely' or 'almost never', then this would indicate that the facility's response was inaccurate.

Appendix F

An example of Key elements - Credentialling

All medical practitioners and dentists have their clinical privileges delineated at the time of appointment and re-appointment and as part of the performance review process.

The role and infrastructure of the relevant facility is taken into account in determining the clinical privileges that will be allowed.

The AHS has processes in place to specify facility role delineation and is reassessed when changes in facility resource and infrastructure occur. The role delineation will specify the level of clinical services that can be provided safely and is appropriately supported within a health facility as determined by the available support services, staff profile, minimum safety standards and other requirements. There is a process for review of clinical privileges throughout the period of employment or appointment.

The assessment of clinical privileges is undertaken by peers and associated professionals.

Robust information including safety and quality outcomes or process data is available to those assessing re-appointment.

The review process identifies improved performance and/or advances in skills and competencies or identification of matters that may compromise quality of care.

Appendix G

Accreditation mapping

This section outlines the potential links between the answers to activity statement questions, and existing Equip4 criteria.

How to use this information

The following table lists all the questions from the clinical unit, health facility and Area Health Service Activity Statements of the Quality Systems Assessment program (QSA). Alongside each of these activity statement questions, the column 'ACHS criterion' lists any criterion from Equip 4 which may relate to the QSA question. It should be noted that the list of ACHS criteria is comprehensive and identifies only that the criterion and activity statement question relate to the same subject matter. It does not mean that the ACHS criterion asked for exactly the same information as the activity statement question.

The relevant ACHS criteria are only listed where there is a possible link between the information requested in the activity statement question and a minimum standard of SA for that ACHS criterion.

Limitations

It should be noted that there is a more direct link between some of the criteria listed than others. As an example, the Clinical Unit activity statement question 16 part c) asks respondents whether the clinical unit measures outcomes subsequent to the introduction of a new intervention/procedure or drug. There are three criteria that are identified as potentially relevant to this activity statement question.

Criterion 1.4.1 has the most potential for a direct link: to obtain a rating of EA, the organisation must 'undertake research into the effectiveness of interventions and services and on the adoption of evidence into practice'. It is possible that when submitting the evidence to support their application to obtain an EA for this criterion, the organisation may

have provided evidence of units measuring outcomes subsequent to the introduction of the new intervention/procedure or drug. As such, the organisation's submission for this ACHS criterion may be a source of evidence to verify the accuracy of the respondent's answer to the QSA question.

For this activity statement question however, there is an additional criterion that may provide relevant evidence. To obtain a rating of SA for this criterion, the organisation must demonstrate 'formal processes are in place across the organisation for the review of clinical care'. While there are a broad range of processes that an organisation might list, reviewing outcomes following the introduction of a new intervention/procedure or drug may be one piece of evidence listed. As such, the response to this ACHS standard is a possible, though not strong, link.

Clinical Unit

Level & Question number	Activity Statement Question	ACHS criterion	Mandatory / non mandatory
Unit 1	What are the 3 highest risks to patient safety in your clinical unit? Risks should be specific to the unit or service and have the potential for performance improvement. For example post-operative wound infection, missed diagnosis, falls, perforated bowel, management of thrombolytic therapy, wrong medication	Criterion 2.1.2	Mandatory
Unit 2	How are safety and quality issues or clinical risks identified?	Criterion 2.1.2	Mandatory
Unit 3	What activities or interventions are in place to manage these risks? For example a clinical protocol is in place that specifies indications for and details of VTE prophylaxis; periodic audit to evaluate compliance to protocol; regular analysis of reported incidence of DVT or PE.	Criterion 2.1.2	Mandatory
Unit 4	What are the three most important Clinical Indicators or Key Performance Indicators (KPI) that are used in the unit. For example infection rate, unplanned returns to theatre. If you collect and submit clinical indicators to a national registry you may opt to name the registry	Criterion 1.1.4 Criterion 2.3.3	Mandatory Mandatory
Unit 5	What is the source of the indicator information?		
Unit 6	Do you compare performance of clinical indicators with other units?	Criterion 1.1.4 Criterion 2.3.3	Mandatory Mandatory

Level & Question number	Activity Statement Question	ACHS criterion	Mandatory / non mandatory
Unit 7	How often are indicators reported to the next level of management?		
Unit 8	Have patient safety and clinical quality initiatives been undertaken in the last 12 months in the unit as a result of clinical indicator or clinical incident data?	Criterion 2.1.3	Mandatory
Unit 9	Please provide details of these initiatives – include project aim, performance measures and results achieved		
Unit 10	Does the unit have a forum/meeting for the discussion of patient safety and quality issues such as indicator performance, incidents and complaints? For example is there a standing agenda item in a staff meeting or Morbidity & Mortality meeting.	Criterion 1.1.4	Mandatory
Unit 11	What information is discussed at the forum/meeting?	Criterion 1.1.4	Mandatory
Unit 12	Choose the option which describes most closely the frequency with which these meetings are held		
Unit 13	Who attends these meetings?		
Unit 14	Please select the option that you think most closely describes the frequency of the following activities within the unit a) SAC 1 and SAC 2 incidents are reported within 24 hours	Criterion 2.1.3	Mandatory
	b) IIMS is used to enter data on clinical incidents	Criterion 2.1.3	Mandatory

Level & Question number	Activity Statement Question	ACHS criterion	Mandatory / non mandatory
	c) IIMS is used to enter data on complications of care such as post operative haemorrhage or post operative infection	Criterion 2.1.3	Mandatory
	d) Falls prevention interventions are in place appropriate to the assessed risk	Criterion 1.5.4	
	e) All deaths in the unit are reviewed	Criterion 1.1.4 Criterion 2.1.3	Mandatory Mandatory
	f) Information regarding outcomes of death review, RCAs and analysis of incidents is fed back to staff	Criterion 2.1.3	Mandatory
	g) SAC 3 & 4 incident data reports are provided to the unit	Criterion 2.1.3	Mandatory
	h) Appropriate changes are made as a consequence of incident investigation findings and recommendations	Criterion 2.1.3	Mandatory
	i) Periodic audits of clinical practice for high risk processes and procedures	Criterion 1.1.4 Criterion 1.4.1	Mandatory Not mandatory
	j) Feedback to staff of results of clinical audits		
Unit 15	a) When SAC 1 or SAC 2 clinical incident occurs a seniot clinician involved in the care of the patient acknowledges the incident to the patient or their carer		

Level & Question number	Activity Statement Question	ACHS criterion	Mandatory / non mandatory
	b) An apology or expression of regret is provided to the patient when an adverse event occurs		
	c) An explanation of known facts is provided after an adverse event		
	d) A timeframe is agreed with the patient or their support person/carer to discuss causes when the investigation is complete and to update progress		
	e) The open disclosure process is recorded in the medical record		
Unit 16	a) When a new interventional procedure is introduced notification is sent to the relevant group/committe for approval		
	b) When a new drug is introduced notification is sent to the relevant group/committe for approval	Criterion 1.5.1	Not mandatory
	c) The clinical unit measures outcomes subsequent to the introduction of a new intervention/procedure or drug	Criterion 1.1.4 Criterion 1.4.1	Mandatory Not mandatory
	d) JMOs receive training in safe prescribing		
	e) Audits of the NIMC are performed using the NIMC audit tool		

Level & Question number	Activity Statement Question	ACHS criterion	Mandatory / non mandatory
Unit 17	How often do the following Infection control activities occur within the unit: a) hand washing occurs between patients		
	b) hand washing occurs before and after touching blood or other contaminants regardless of whether gloves were used		
	c) gloves are worn during procedures or patient contact where activities are likely to generate splashes or sprays, suctioning a patient, performing invasive procedures, venepuncture or finger/heel stick?		
	d) alcohol based hand-rub is situated near patient location		
	e) observational studies of hand washing within clinical areas every month	Criterion 1.1.4 Criterion 1.5.2	Mandatory Mandatory
Unit 18	Do activities for ensuring correct patient, correct site, correct procedure include: a) a valid, documented consent for significant procedures or those involving significant risk?	Criterion 1.5.6	Not mandatory
	b) left and right is written out in full in documented consent?	Criterion 1.5.6	Not mandatory

Level & Question number	Activity Statement Question	ACHS criterion	Mandatory / non mandatory
	c) operative sites are marked while patient is awake (where appropriate)?	Criterion 1.5.6	Not mandatory
Unit 18	d) patient participates in operative site marking (where appropriate)?	Criterion 1.5.6	Not mandatory
	e) participating clinicians independently verify patient procedure and site?	Criterion 1.5.6	Not mandatory
	f) a “time out” just prior to commencement of the procedure during which patient identify site and procedure are confirmed?	Criterion 1.5.6	Not mandatory
Unit 19 Unit 19	a) Which of the following best describes the frequency with which blood transfusions are performed within the unit?		
	Please select the option that you think most closely describes the frequency of the following activities in relation to blood transfusion practice. b) for each transfusion the indication and evidence for likely benefit is defined	Criterion 1.5.5	Not mandatory
	c) a valid, documented consent for the blood transfusion	Criterion 1.1.3 Criterion 1.5.5	Mandatory Not mandatory

Level & Question number	Activity Statement Question	ACHS criterion	Mandatory / non mandatory
	d) two people independently check the details of the patient identity, the blood pack and documentation when transfusions are set up	Criterion 1.5.5	Not mandatory
	e) adverse events related to the transfusion are reported to a staff member with responsibility for oversight of transfusion safety	Criterion 1.5.5	Not mandatory
Unit 20	There is a positive patient safety and quality culture within the unit.		
Unit 21	In the last two years has there been an improvement in the safety and quality of patient care within the unit.		
Unit 22	Approximately what percentage of staff within the unit underwent an annual performance review in the previous 12 months?		

Facility Level

Level & Question number	Activity Statement Question	ACHS criterion	Mandatory / non mandatory
Facility 1	What is the peak group or committee that decides about quality and clinical risk issues?		

Level & Question number	Activity Statement Question	ACHS criterion	Mandatory / non mandatory
Facility 2	Which of the following issues does the group/committee named in the previous question review?	3.1.2	Non-mandatory
Facility 3	Provide an example of the group/committee response to a patient safety & quality issue?		
Facility 4	This group/committee provides effective governance for patient safety and clinical quality issues.		
Facility 5	List the hospital wide Clinical Indicators collected. If you collect more than ten only list the ten which facility management consider the most important in monitoring safety and quality systems.	Criterion 1.1.4 Criterion 2.3.3	Mandatory Mandatory
Facility 6	How is clinical indicator performance fed back to clinical units?		
Facility 7	When there is unsatisfactory performance in a clinical indicator how does facility management respond? Unsatisfactory performance may be where measures are below benchmark values or NSW Health targets.		
Facility 8	Does the facility compare its performance on safety and quality indicators with other facilities?	Criterion 1.1.4 Criterion 2.3.3	Mandatory Mandatory
Facility 9	How do you compare performance on clinical indicators?	Criterion 1.1.4	Mandatory

Level & Question number	Activity Statement Question	ACHS criterion	Mandatory / non mandatory
Facility 10	On occasions where there are patient safety and quality issues that you are unable to manage locally, how do you refer the matter to AHS management?		
Facility 11	How are safety and quality issues or clinical risks identified?		
Facility 12	What are the 3 highest risks to patient safety in the facility? Risks may include a range of issues for example, staffing mix or failure to identify a deteriorating patient.		
Facility 13	What activities or interventions are in place to manage the three highest risks listed in Q12?		
Facility 14	Does the facility keep a risk register that includes patient safety and clinical quality risks?		
Facility 15	Does information provided by clinical units inform the risks on the register?		
Facility 16	The facility has an integrated risk management system	Criterion 2.1.2	Mandatory
Facility 17	Does the facility use information about clinical risks to prioritise patient safety and quality improvement project initiatives within the facility?	Criterion 2.1.2	Mandatory
Facility 18	How does the facility prioritise patient safety and quality improvement projects?		

Level & Question number	Activity Statement Question	ACHS criterion	Mandatory / non mandatory
Facility 19	How many patient safety and quality improvement project initiatives are currently being undertaken within the facility?		
Facility 20	List details of two improvement project initiatives that are being coordinated at facility level to improve the quality and/or safety of patient care.		
Facility 21	Please describe procedures in place to communicate patient safety alerts to clinical units		
Facility 22	How does the facility follow up changes made in response to patient safety alerts? Please provide a description of actions taken in response to Safety Alert 001/07 Fine Bore Nasogastric Feeding Tubes – 3 May 2007 as an example.		
Facility 23	Please describe procedures in place to communicate changes patient safety and clinical quality policies and protocols to clinical units?	Criterion 3.1.5	Mandatory
Facility 24	How does the facility ensure relevant changes are made in response to changes in safety and quality policies and protocols?	Criterion 3.1.5	Mandatory
Facility 25	Is there a process for 'immediate' (<24 hours) notification of serious incidents to the facility management team?		

Level & Question number	Activity Statement Question	ACHS criterion	Mandatory / non mandatory
Facility 26	How often is the process for immediate notification of serious incidents followed?		
Facility 27	Does the facility receive information regarding the outcomes and recommendations of RCA analysis?	Criterion 2.1.3	Mandatory
Facility 28	What process does the facility have in place to monitor changes made in response to RCA recommendations?	Criterion 1.1.4 Criterion 2.1.3	Mandatory Mandatory
Facility 29	Does the facility perform detailed investigations of SAC 2 clinical incidents?	Criterion 1.1.4 Criterion 2.1.3	Mandatory Mandatory
Facility 30	How does the facility investigate SAC 2 clinical incidents?	Criterion 1.1.4 Criterion 2.1.3	Mandatory Mandatory
Facility 31	Does the facility review and analyse trended data for SAC 3 and 4 incidents?	Criterion 1.1.4 Criterion 2.1.3	Mandatory Mandatory
Facility 32	Describe the process for analysis of trended incident data. Please include the elements analysed such as principle incident types, location of incident etc.	Criterion 1.1.4 Criterion 2.1.3 Criterion 2.3.3	Mandatory Mandatory Mandatory

Level & Question number	Activity Statement Question	ACHS criterion	Mandatory / non mandatory
Facility 33	Please select the option that you think most closely describes the frequency of the following activities in relation to open disclosure. a) When an adverse event occurs a senior clinician involved in the care of the patient acknowledges the incident to the patient or their support person/carer b) An apology or expression of regret is provided to the patient when an adverse event occurs c) An explanation of known facts is provided d) A timeframe is agreed with the patient or their support person/carer to discuss causes when the investigation is complete and to update progress e) The open disclosure process is recorded in the medical record f) Support persons/carers are notified when incidents are referred to the coroner g) Support or advice from a senior colleague with experience in the open disclosure process is available to clinicians if requested h) Training in open disclosure is available	Criterion 2.1.3	Mandatory

Level & Question number	Activity Statement Question	ACHS criterion	Mandatory / non mandatory
Facility 34	How does the facility manage a complaint or concern against a clinician? Please describe the process for activation of the policy managing complaints and concerns against a clinician both through an RCA and though a direct complaint.	Criterion 2.1.3	Mandatory
Facility 35	What protocols does the facility have in place to review all deaths? Please describe death review within the facility.	Criterion 1.1.4	Mandatory
Facility 36	Does the facility provide feedback to clinical units on the review of unexpected deaths?		
Facility 37	Unexpected deaths are reported into IIMS.		
Facility 38	Does the facility review information from clinical units about patient complaints?	Criterion 1.1.4 Criterion 2.1.3	Mandatory Mandatory
Facility 39	Is complaints data analysed at the facility level to detect trends?	Criterion 1.1.4 Criterion 2.1.3	Mandatory Mandatory
Facility 40	Select the option which most closely describes the frequency with which complaints data is analysed and trended by the facility:	Criterion 2.1.3	Mandatory
Facility 41	How does the facility inform consumers about how to make a complaint?	Criterion 2.1.3	Mandatory

Level & Question number	Activity Statement Question	ACHS criterion	Mandatory / non mandatory
Facility 42	Does the facility use any of the following activities to proactively identify the issues and concerns of patients and carers?	Criterion 1.1.4 Criterion 1.6.1	Mandatory Not mandatory
Facility 43	Is a risk assessment completed before a new interventional procedure is introduced?	Criterion 3.1.3	Mandatory
Facility 44	How often is a credentialling process used for clinicians who will be performing the new interventional procedure?	Criterion 3.1.3	Mandatory
Facility 45	Where the new procedure or intervention requires training in new skills, does the facility require evidence of this training to be provided as part of the credentialling process?	Criterion 3.1.3	Mandatory
Facility 46	How often does the facility review outcomes subsequent to the introduction of a new interventional procedure?	Criterion 1.1.4 Criterion 3.1.3	Mandatory Mandatory
Facility 47	Is a risk assessment completed before new drug therapy is introduced?	Criterion 1.5.1 Criterion 3.1.3	Not mandatory Mandatory
Facility 48	Has the facility completed the Medication Safety Self Assessment?		
Facility 49	Please describe the facility governance strucures for drug safety.		

Level & Question number	Activity Statement Question	ACHS criterion	Mandatory / non mandatory
Facility 50	Please describe the process for approval of new drug therapies including any risk assessment and review of outcomes following introduction.	Criterion 3.1.3	Mandatory
Facility 51	Has the facility implemented the National Inpatient Medication Chart (NIMC)?		
Facility 52	Do activities occur within the facility to support safe prescribing and implementation of NIMC include:		
	a) medication chart audits using the NIMC audit tool		
	b) other audits of medication chart & prescribing		
	c) monitoring of audit results by clinicians		
	d) monitoring of audit results by management		
	e) education in use of NIMC		
Facility 53	Do activities within the facility for ensuring correct patient, correct site, correct procedure include: a) a valid, documented consent?	Criterion 1.1.3 Criterion 1.5.6	Mandatory Not mandatory
	b) left and right is written out in full in documented consent	Criterion 1.5.6	Not mandatory

Level & Question number	Activity Statement Question	ACHS criterion	Mandatory / non mandatory
	c) operative sites are marked while patient is awake (where appropriate)?	Criterion 1.5.6	Not mandatory
	d) patient participates in operative site marking (where appropriate)?	Criterion 1.5.6	Not mandatory
	e) participating clinicians independently verify patient procedure and site?	Criterion 1.5.6	Not mandatory
	f) a “time out” just prior to commencement of the procedure during which patient identify site and procedure are confirmed?	Criterion 1.5.6	Not mandatory
Facility 54	How do you verify that correct patient, correct site, correct procedure activities are occurring?	Criterion 1.1.4 Criterion 1.5.6	Mandatory Not mandatory
Facility 55	Does the facility have a committee responsible for the review of transfusion issues?	Criterion 1.5.5	Not mandatory
Facility 56	Is there a team, unit or department responsible for improving the safety of transfusion and the use of blood products?	Criterion 1.5.5	Not mandatory
Facility 57	Please identify which of the following activities that this entity undertakes (education, monitoring, quality improvement, other)	Criterion 1.5.5	Not mandatory

Level & Question number	Activity Statement Question	ACHS criterion	Mandatory / non mandatory
Facility 58	Which of the following receive feedback about their performance in relation to the management of fresh blood components?		
Facility 59	How often does the process for ensuring safe blood transfusions within the facility include: a) a valid, documented consent for the blood transfusion?	Criterion 1.1.3 Criterion 1.5.5	Mandatory Not mandatory
	b) specimens are labelled at the time of collection from the patient?	Criterion 1.5.5	Not mandatory
	c) at the time of collection specimens are checked by a staff member and the patient or two staff members?	Criterion 1.5.5	Not mandatory
	d) two people independently check the details of the patient identity, the blood pack and documentation when transfusions are set up?	Criterion 1.5.5	Not mandatory
	e) for each transfusion the indication and evidence for likely benefit is defined?		
	f) adverse events related to the transfusion are reported to transfusion CNC or equivalent?		
Facility 60	How do you verify that processes for ensuring correct transfusions are occuring?	Criterion 1.1.4	Mandatory

Level & Question number	Activity Statement Question	ACHS criterion	Mandatory / non mandatory
Facility 61	Does the facility have a policy framework for infection control?	Criterion 1.5.1	Mandatory
Facility 62	Please list which infection rates the facility monitors? For example Health Associated Infection (HAI) Surgical Site Infections, peripheral cannuale infection rate, central line infection rate.	Criterion 1.5.1	Mandatory
Facility 63	What action is taken when infection rates deteriorate?	Criterion 1.5.1	Mandatory
Facility 64	How often do the following infection control activities occur: a) hand washing between patients?	Criterion 1.1.4	Mandatory
	b) hand washing before and after touching blood or other contaminants regardless of whether gloves were used?	Criterion 1.1.4	Mandatory
	c) gloves are worn during procedures or patient contact where activities are likely to generate splashes or sprays, suctioning a patient, performing invasive procedures, venepuncture or finger/heel stick	Criterion 1.1.4	Mandatory
	d) gloves are changed between each patient?	Criterion 1.1.4	Mandatory
	e) fluid resistant gowns are worn during procedures or patient contact where activities are likely to generate splashes or sprays?	Criterion 1.1.4	Mandatory
	f) alcohol based hand-rub is situated near patient location?	Criterion 1.1.4	Mandatory

Level & Question number	Activity Statement Question	ACHS criterion	Mandatory / non mandatory
	g) observational studies of hand washing within clinical areas every month?	Criterion 1.1.4	Mandatory
Facility 65	Does the facility have a functioning medical record review program?	Criterion 1.1.4 Criterion 1.1.8	Mandatory Mandatory
Facility 66	Which of the following characteristics reflects your medical record review program?	Criterion 1.1.4 Criterion 1.1.8	Mandatory Mandatory
Facility 67	How is the medical record review program used to improve the safety and quality of patient care?	Criterion 1.1.8	Mandatory
Facility 68	Does clinician peer review occur within the facility?	Criterion 1.4.1	Not mandatory
Facility 69	Please describe the peer review process	Criterion 1.4.1	Not mandatory
Facility 70	How is peer review program used to improve the safety and quality of patient care?	Criterion 1.4.1	Not mandatory
Facility 71	Who receives information regarding the relevant results from peer review activities?		

Level & Question number	Activity Statement Question	ACHS criterion	Mandatory / non mandatory
Facility 72	Are audits of clinical practice carried out in your facility? These may include an audit on percentage of patients receiving appropriate venous thromoebmolism prophylaxis, chest drain management audit.		
Facility 73	Please describe the process for clinical audit used		
Facility 74	Identify which of the following receive feedback on results of the clinical audits.		
Facility 75	How is clinical audit information used to improve the safety and quality of patient care?	Criterion 1.4.1	Not Mandatory
Facility 76	Is there a process that is followed for delineation of clinical privileges for medical practitioners?	Criterion 3.1.3	Mandatory
Facility 77	Is there a process that is followed for the delineation of clinical privileges for all dentists?	Criterion 3.1.3	Mandatory
Facility 78	For each classification of health professional please note the frequency with which a formal performance review process is carried out.	Criterion 2.2.3	Not Mandatory
Facility 79	How does the performance review process identify matters that may compromise quality of care?		

Level & Question number	Activity Statement Question	ACHS criterion	Mandatory / non mandatory
Facility 80	If clinical practice issues are identified that compromise the quality of patient care how is the process managed within the facility?	Criterion 2.2.3	Not Mandatory
Facility 81	How does the facility ensure clinicians and managers have skills in the management of quality and patient safety? For example skills in data analysis and quality improvement.		

AHS

AHS 1	Has the Area Health Service clearly stated its undertaking to patient safety and clinical quality within its: a) mission statement; b) strategic plan; c) operational plan	Criterion 3.1.1	Not mandatory
AHS 2	Has the AHS established a Health Care Quality (or equivalent) Committee?		
AHS 3	Does the Health Care Quality (or equivalent) Committee review the following: a) reports on SAC 1 incident investigations; b) trended data or other information regarding SAC 2 SAC 3 or SAC 4 incidents; complaints management performance; d) clinical indicator performance; e) outcomes of death reviews; f) progress on implementation of safety and quality policies	Criterion 1.1.4 Criterion 2.1.3	Mandatory Mandatory
AHS 4	How does the Health Care Quality Committee (or equivalent) respond to patient safety and clinical quality issues identified by facilities within the AHS? Please include one example.		

AHS 5	Is the CE a member of the Health Care Quality Committee (or equivalent)?		
AHS 6	If the Chief Executive is not a member of the Health Care Quality Committee (or equivalent) describe how findings and issues are communicated to the Chief Executive. Provide an example to demonstrate the effectiveness of this communication.		
AHS 7	List the Area-wide clinical indicators reported to the AHS by facilities. If you collect more than ten, only list the ten which you consider the most important in monitoring safety and quality systems	Criterion 2.3.3	Mandatory
AHS 8	How does the AHS respond to poor performance in these clinical indicators?		
AHS 9	How has benchmarking safety and quality clinical indicators resulted in improvement? Give one example from the last 12 months.	Criterion 1.1.4	Mandatory
AHS 10	What are the three highest risks to patient safety within the AHS?		
AHS 11	What activities or interventions are in place to manage the three highest risks listed in Q 10?		
AHS 12	Does the Audit and Risk Management Committee (or equivalent) review clinical risk as well as financial and other corporate risks?		

AHS 13	Please list all clinical risks reviewed by the Audit and Risk Management Committee (or equivalent) within the period 1 January 2006 to 31 December 2006.	Criterion 2.1.2	Mandatory
AHS 14	Overall, the governance of clinical, corporate, and environmental risk is integrated at AHS level.	Criterion 2.1.2	Mandatory
AHS 15	Is the AHS conducting any Area-wide patient safety and clinical quality improvement initiatives that are not part of a state-wide initiative?		
AHS 16	Describe how a safety and quality improvement project has improved the safety of patient care. Please include project aims, outcomes and achievements		
AHS 17	Does the Clinical Governance Unit have a business/work plan?	Criterion 3.1.1	Not mandatory
AHS 18	Has the business/work plan been endorsed by the AHS Chief Executive?		
AHS 19	Has the Clinical Governance Unit business/work plan been implemented?		
AHS 20	How is the CGU business plan actively monitored and progress against it's objectives reviewed?	Criterion 3.1.1	Not mandatory
AHS 21	Describe how the AHS reports clinical quality and patient safety performance to the public.		
AHS 22	Please describe procedures in place to communicate patient safety alerts to facilities within the AHS		

AHS 23	How does the AHS follow up that changes have been made in response to patient safety alerts?		
AHS 24	Please describe procedures in place to communicate changes in patient safety and clinical quality policies and protocols to facilities within the AHS	Criterion 3.1.5	Mandatory
AHS 25	How does the AHS follow up that modifications have been made in response to changes in patient safety and clinical quality policies and protocols?	Criterion 3.1.5	Mandatory
AHS 26	Does the AHS have a policy framework for incident management?		
AHS 27	How often is SAC 1, 2, 3 and 4 clinical incident data grouped and trended for analysis (select the closest frequency for each group)?	Criterion 1.1.4 Criterion 2.1.3	Mandatory Mandatory
AHS 28	What level of management receive trended incident data reports?	Criterion 2.1.3	Mandatory
AHS 29	How is information on analysis of clinical incidents, RCAs and recommendations provided to the groups listed in the question above?	Criterion 2.1.3	Mandatory
AHS 30	What system does the AHS have in place to monitor changes that are made in response to investigation and analysis of clinical incidents?	Criterion 2.1.3	Mandatory
AHS 31	Provide an example of improvement activities undertaken at AHS level as a result of recommendations from analysis of clinical incident data	Criterion 2.1.3	Mandatory

AHS 32	Does the AHS perform detailed investigations of SAC 2 incidents?	Criterion 1.1.4 Criterion 2.1.3	Mandatory Mandatory
AHS 33	Does the AHS have an established process for open disclosure following a serious clinical incident?	Criterion 2.1.3	Mandatory
AHS 34	How does the AHS manage open disclosure for high level (SAC 1 or SAC 2) adverse events?		
AHS 35	Does the AHS have a policy framework/ protocol for the management of a complaint or concern about a clinician?		
AHS 36	Does the AHS have a process for management of a complaint or concern about a clinician?		
AHS 37	How does the AHS monitor the performance of the incident management systems? For example are audits of RCA processes performed to evaluate compliance with policy requirements?	Criterion 1.1.4 Criterion 2.1.3	Mandatory Mandatory
AHS 38	Has the person with responsibility for managing the IIMS database for the AHS received training to ensure they have skills required for their role as IIMS manager?		
AHS 39	Is there an AHS policy framework or guideline for review of all deaths?		
AHS 40	What organisational level has responsibility for death review?		
AHS 41	Does the AHS receive information or trended data from facilities, streams or units about death review?	Criterion 1.1.4	Mandatory

AHS 42	Please list information received		
AHS 43	Are reported untimely deaths notified as an incident on the IIMS system?		
AHS 44	Does the AHS audit performance in relation to the required reporting of deaths to NSW Health special committees?		
AHS 45	Does the AHS have a policy framework for the management of complaints by patients or their carers?		
AHS 46	List information the AHS reviews in relation to patient complaints.	Criterion 1.1.4	Mandatory
AHS 47	If the length of time it takes to respond to complaints increases significantly, what action is taken?		
AHS 48	Is complaints data analysed to identify trends at AHS level?		
AHS 49	How is complaints data analysed? (eg complaint type, response times by clinician, unit, facility).		
AHS 50	To whom does the AHS report data on analysed complaints?		
AHS 51	How often is complaints data analysed?		
AHS 52	How does the AHS inform its consumers about how to make a complaint?		
AHS 53	Does the AHS have a policy framework for managing complaints or concerns about a clinician?		

AHS 54	Does the AHS receive information on complaints against clinicians? For example, number of complaints by clinicians; number that lead to disciplinary action; number that have industrial body involvement.		
AHS 55	Please list information received	Criterion 1.1.4	Mandatory
AHS 56	Does the AHS have a system for support and mediation to assist complainants? For example in the event of a dispute between the hospital and an individual making a complaint, can a mediation process be triggered by the AHS?		
AHS 57	Does the AHS have a policy framework for managing the introduction of new interventional procedures?	Criterion 3.1.3	Mandatory
AHS 58	Does the AHS receive information on new interventional procedures? For example number and nature of new interventional procedures; number that have had performance evaluated after trial implementation or results of the evaluation process.	Criterion 3.1.3	Mandatory
AHS 59	Please list information received	Criterion 1.1.4	Mandatory
AHS 60	Is there an established process used to gain formal approval before new interventional procedures are introduced?	Criterion 3.1.3	Mandatory
AHS 61	Is a risk assessment completed before a new interventional procedure is introduced?	Criterion 3.1.3	Mandatory
AHS 62	How are new interventional procedures approved and what is the follow-up process to monitor outcomes following their introduction?	Criterion 1.1.4 Criterion 3.1.3	Mandatory Mandatory

AHS 63	How are new drugs approved and what is the follow-up process to monitor outcomes following their introduction?	Criterion 1.1.4 Criterion 1.5.1 Criterion 3.1.3	Mandatory Not mandatory Mandatory
AHS 64	Has the AHS implemented the NIMC?		
AHS 65	Does the AHS have a policy framework or guideline on correct patient /site/ procedure?	Criterion 1.5.6	Not mandatory
AHS 66	Does the AHS verify that correct patient/site/procedure processes are occurring? For example audit or observational studies	Criterion 1.1.4 Criterion 1.5.6	Mandatory Not mandatory
AHS 67	Please describe these verification activities		
AHS 68	Does the AHS receive or review any information about the performance of the system and processes in relation to correct patient/site/procedure? For example incomplete consent forms/arrival at OT with site not marked	Criterion 1.1.4	Mandatory
AHS 69	Please list information received.		
AHS 70	Does the AHS have a policy framework on the management of fresh blood components?	Criterion 1.5.5	Not mandatory

AHS 71	Does the AHS receive information about the performance of processes in relation to the management of fresh blood products? e.g. education on transfusion verification procedures, results from labelling audit activities, transfusion appropriateness.	Criterion 1.1.4 Criterion 1.5.5	Mandatory Not mandatory
AHS 72	Please list information received		
AHS 73	What infection control indicators are monitored at AHS level?	Criterion 1.1.4 Criterion 1.5.2	Mandatory Mandatory
AHS 74	Does the AHS have a policy framework or guideline for medical record review?		
AHS 75	If there is a medical record review program within the AHS, are the findings of this program reported to the Area Health Care Quality Committee?		
AHS 76	Does the AHS receive information about the findings of medical record review?	Criterion 2.1.3	Mandatory
AHS 77	Please list information received		
AHS 78	Does the Area Health Service have a policy framework or guideline for peer review in clinical departments?	Criterion 1.1.4	Mandatory
AHS 79	Does the AHS have a policy framework or guideline for clinical audits?	Criterion 1.4.1	Not mandatory
AHS 80	Does the AHS carry out regular or ad hoc clinical audit activities?	Criterion 1.1.4	Mandatory

AHS 81	Identify which of the following receive feedback on relevant results of the clinical audits.		
AHS 82	Does the AHS have a policy framework or guideline outlining roles and responsibilities in defining an individual clinician's clinical privileges?	Criterion 3.1.3	Mandatory
AHS 83	Does the AHS have a process for the review of clinical privileges throughout the period of appointment/ employment of VMOs or staff specialists?	Criterion 3.1.3	Mandatory
AHS 84	Is there an AHS policy framework or guideline outlining roles and responsibilities in credentialling health professionals?	Criterion 3.1.3	Mandatory
AHS 85	Does the AHS review hospital role delineation as part of regular AHS services plan development?		
AHS 86	Are existing support service levels at individual facilities assessed and categorised according to the framework outlined in the Guide to Role Delineation of Health Services when determining individual facility role delineation?		

Appendix H

Sites Participating in the Pilot

The tables below identify all sites that were identified to be part of the pilot project and subsequently sent the links and information to complete the relevant activity statement. The profession of the site's main contact person is also noted.

Sydney South West Area Health Service

PHO	Level	Name	Contact Profession
AHS	AHS	Sydney South West AHS – Clinical Governance Unit	Director of Clinical Governance
AHS	Facility	Bankstown Hospital	Facility Quality Manager
AHS	Unit/ Department	Bankstown Hospital - Aged Care	Medical
AHS	Unit/ Department	Bankstown Hospital – Aged Psychiatry	Medical
AHS	Unit/ Department	Bankstown Hospital – Cardiology	Medical
AHS	Unit/ Department	Bankstown Hospital – Oncology	Medical
AHS	Unit/ Department	Bankstown Hospital – Ambulatory Care	Medical
AHS	Unit/ Department	Bankstown Hospital – Respiratory	Medical
AHS	Unit/ Department	Bankstown Hospital – Rheumatology	Medical

PHO	Level	Name	Contact Profession
AHS	Unit/ Department	Bankstown Hospital – Hypertension	Medical
AHS	Unit/ Department	Bankstown Hospital – Endocrine	Medical
AHS	Unit/ Department	Bankstown Hospital – Gastro	Medical
AHS	Unit/ Department	Bankstown Hospital - Neurology	Medical
AHS	Unit/ Department	Bankstown Hospital – Radiology	Medical
AHS	Unit/ Department	Bankstown Hospital – Nuclear Medicine	Medical
AHS	Unit/ Department	Bankstown Hospital - ENT	Medical
AHS	Unit/ Department	Bankstown Hospital – Surgery	Medical
AHS	Unit/ Department	Bankstown Hospital – Plastics	Medical
AHS	Unit/ Department	Bankstown Hospital – Urology	Medical
AHS	Unit/ Department	Bankstown Hospital – Neurosurgery	Medical
AHS	Unit/ Department	Bankstown Hospital – Orthopaedics	Medical
AHS	Unit/ Department	Bankstown Hospital – Ophthalmology	Medical

PHO	Level	Name	Contact Profession
AHS	Unit/ Department	Bankstown Hospital – Obstetrics & Gynaecology	Medical
AHS	Unit/ Department	Bankstown Hospital – Paediatrics	Medical
AHS	Unit/ Department	Bankstown Hospital – Emergency	Medical
AHS	Unit/ Department	Bankstown Hospital – ICU	Medical
AHS	Unit/ Department	Bankstown Hospital – Anaesthetics	Medical
AHS	Unit/ Department	Bankstown Hospital – Psychiatry	Medical
AHS	Unit/ Department	Bankstown Hospital – Renal	Medical

Greater Western Area Health Service

PHO	Level	Name	Contact Profession
AHS	AHS	Greater Western AHS – Clinical Governance Unit	Director of Clinical Governance
AHS	Facility	Central Cluster	Cluster General Manager
AHS	Unit/ Department	Dubbo Base Hospital – Surgical	NUM
AHS	Unit/ Department	Dubbo Base Hospital – Medical	NUM

PHO	Level	Name	Contact Profession
AHS	Unit/ Department	Dubbo Base Hospital – Obstetrics	NUM
AHS	Unit/ Department	Dubbo Base Hospital – Emergency	NUM
AHS	Unit/ Department	Dubbo Base Hospital – Intensive Care	NUM
AHS	Unit/ Department	Dubbo Base Hospital – Paediatrics	NUM
AHS	Unit/ Department	Mudgee District Hospital – Medical/Surgical	NUM
AHS	Unit/ Department	Mudgee District Hospital – Obstetrics	NUM
AHS	Unit/ Department	Mudgee District Hospital – Emergency	NUM
AHS	Unit/ Department	Rylestone Multipurpose Service	Health Service Manager

North Coast Area Health Service

PHO	Level	Name	Contact Profession
AHS	AHS	North Coast AHS – Clinical Governance Unit	Patient Safety Manager
AHS	Facility	Coffs Harbour Health Campus	Quality Manager
AHS	Facility	Bellingen River District Hospital	Facility Quality Manager

PHO	Level	Name	Contact Profession
AHS	Unit/ Department	Coffs Harbour Base Hospital - Oncology	NUM
AHS	Unit/ Department	Coffs Harbour Base Hospital – Paediatric & Adolescent Unit	NUM
AHS	Unit/ Department	Coffs Harbour Base Hospital – Coronary Angiography Unit	NUM
AHS	Unit/ Department	Coffs Harbour Base Hospital – Day Procedure Unit	Nurse Manager
AHS	Unit/ Department	Coffs Harbour Base Hospital – Emergency Department	NUM
AHS	Unit/ Department	Coffs Harbour Base Hospital – Intensive Care Unit	NUM
AHS	Unit/ Department	Coffs Harbour Base Hospital – Medical Assessment and Planning Unit	NUM
AHS	Unit/ Department	Coffs Harbour Base Hospital – Medical Unit	NUM
AHS	Unit/ Department	Coffs Harbour Base Hospital – Maternity Unit	NUM
AHS	Unit/ Department	Coffs Harbour Base Hospital – Medical Imaging	Chief Radiographer

PHO	Level	Name	Contact Profession
AHS	Unit/ Department	Coffs Harbour Base Hospital – Operating Theatre	NUM
AHS	Unit/ Department	Coffs Harbour Base Hospital – Pathology Department	Lab Manager
AHS	Unit/ Department	Coffs Harbour Base Hospital - Pharmacy	Director
AHS	Unit/ Department	Coffs Harbour Base Hospital – Rehabilitation Unit	NUM
AHS	Unit/ Department	Coffs Harbour Base Hospital – Renal Unit	NUM
AHS	Unit/ Department	Coffs Harbour Base Hospital – Surgical Unit	NUM
AHS	Unit/ Department	Dorrigo Multipurpose Service	NUM
AHS	Unit/ Department	Dorrigo Multipurpose Service – Physiotherapy	Physiotherapist
AHS	Unit/ Department	Bellinger River District Hospital – ED and OT	NUM
AHS	Unit/ Department	Bellinger River District Hospital – subacute unit (medical, maternity & day procedures)	NUM
AHS	Unit/ Department	Bellinger River District Hospital – medical unit (primarily long stay)	NUM

PHO	Level	Name	Contact Profession
AHS	Unit/ Department	Bellinger River District Hospital – Occupational Therapy	Occupational Therapist

Justice Health

PHO	Level	Name	Contact Profession
Justice Health	Area	Justice Health – Clinical Governance Unit	Director of Clinical Governance
Justice Health	Stream	Drug and Alcohol Service	Strategic Manager, D&A service
Justice Health	Stream	Mental Health	A/ Deputy Director Statewide Forensic Mental Health Services
Justice Health	Clinic/ Operational Unit	Oral Health	Manager Oral Health Services
Justice Health	Clinic/ Operational Unit	Long Bay Hospital – B Ward (mental health)	NUM
Justice Health	Clinic/ Operational Unit	Statewide Community and Court Liaison Service	Operations Manager
Justice Health	Clinic/ Operational Unit	Statewide Community and Court Liaison Service – Lismore Local Court	CNC
Justice Health	Clinic/ Operational	Mid North Coast Correctional Centre	Nurse Manager

PHO	Level	Name	Contact Profession
	Unit		

NSW Ambulance Service

PHO	Level	Name	Contact Profession
Ambulance	State	NSW Ambulance Service – Clinical Development Unit	Patient Safety Officer
Ambulance	Division	Southern Division	Divisional Manager
Ambulance	Division	Sydney Division	Divisional Manager
Ambulance	Division	Northern Division	Divisional Manager
Ambulance	Division	Western Division	Divisional Manager
Ambulance	Sector	Sydney North Sector	Sector Manager
Ambulance	Sector	Hunter Sector	Sector Manager
Ambulance	Sector	New England Sector	Sector Manager
Ambulance	Sector	Greater Southern Sector	Sector Manager
Ambulance	Sector	Illawarra Sector	Sector Manager

Appendix I

Reporting domains and topics

The following tables outline the domains and topics assessed around which the report will be structured. The domains and topic headings for AHS reports are outlined in Table 1. Domains and topic headings for Justice Health reports are outlined in Table 2. Domains and topic headings for NSW Ambulance Service reports are outlined in Table 3.

Table 1: AHS

Domain	Element
Governance	Governance Committees & Activities
	Clinical Governance Unit (Ambulance - Clinical Development Unit) activities
Risk Management	Identifying, communicating & managing clinical risks
	Credentialling & Role Delineation
Use of Key Performance Indicators or Clinical Indicators	Collection & Reporting
	Analysis & Performance Management
Incident management	Incident reporting & investigation
	Death (mortality) review
	Open disclosure
	Correction of system and process deficiencies
Complaints management	
Review activities	Clinical audit
	Medical record review (Ambulance – Patient health care record review)
	Peer & Performance review
Activities related to management of specific clinical risks	New interventional procedures and drug therapy
	Management of Blood

Domain	Element
	Infection control
	National Inpatient Medication Chart
	Correct patient/site/procedure

Table 2: Justice Health

Domain	Element
Governance	Governance Committees & Activities
Risk Management	Identifying, communicating & managing clinical risks
	Credentialling & Role Delineation
Use of Key Performance Indicators or Clinical Indicators	Collection & Reporting
	Analysis & Performance Management
Incident management	Incident reporting & investigation
	Death (mortality) review Open disclosure
	Correction of system and process deficiencies
Complaints management	
Review activities	Clinical audit Medical record review (Ambulance – Patient health care record review)
	Peer & Performance review
Activities related to management of specific clinical risks	New interventional procedures and drug therapy
	Infection control
	Correct patient/site/procedure

Table 3: NSW Ambulance

Domain	Element
Governance	Governance Committees & Activities
	Clinical Governance Unit (Ambulance - Clinical Development Unit) activities
Risk Management	Identifying, communicating & managing clinical risks
	Credentialling & Role Delineation
Use of Key Performance Indicators or Clinical Indicators	Collection & Reporting
	Analysis & Performance Management
Incident management	Incident reporting & investigation
	Death (mortality) review
	Open disclosure
	Correction of system and process deficiencies
Complaints management	
Review activities	Clinical audit
	Medical record review (Ambulance – Patient health care record review)
	Peer & Performance review
Activities related to management of specific clinical risks	New interventional procedures and drug therapy
	Infection Control
	Ambulance Issue personal Drug Calculator
	BP cuff in Medication Bag