To: COAG Health Council Independent Review of Accreditation Systems within the National Registration and Accreditation Scheme for health professions

From: Consumer

This paper has two parts: definitions of key terminology used in this submission and then ten comments and recommendations made from a consumer and community perspective.

DEFINITIONS

Definitions of terminology as used in this paper are as follows:

**Carers**

*Carers provide unpaid care and support to family members and friends who have a disability, mental illness, chronic condition, terminal illness, an alcohol or other drug issue or who are frail aged.*

Carers Australia @ carersaustralia.com.au

**Community**

*A group of people sharing a common interest (e.g. cultural, social, political, health, economic interests) but not necessarily a particular geographic association. Different types of communities are likely to have different perspectives and approaches to their involvement in research.*


**Consumer**

*Patients and potential patients, carers, and people who use health care services.*

Collectively, ‘consumers’ and ‘community members’ may be referred to as ‘the public’.

The Australian Commission on Safety and Quality in Health Care definition: members of the public who use, or are potential users of health care services - patients, consumers, families, carers and other support people.


**Consumer representative**

*Someone who voices consumer perspectives and takes part in the decision-making process on behalf of consumers.*

This person may be nominated by, and may be accountable to, an organisation of consumers. This consumer representative however may have a narrower view as they are speaking on behalf of their organisation and not necessarily that of the wider community. A consumer representative may be appropriately trained or may undergo training and be supported to advocate for consumer-centred health care.
Consumer-or person- or patient- centred care

Patient or consumer centred care is health care that is respectful of, and responsive to, the preferences, needs and values of patients and consumers and identifies four key principles of patient centred approaches:

- Treating patients, consumers, carers and families with dignity and respect;
- Encouraging and supporting participation in decision making by patients, consumers, carers and families;
- Communicating and sharing information with patients, consumers, carers and families;
- Fostering collaboration with patients, consumers, carers, families and health professionals in program and policy development, and in health service design, delivery and evaluation.

Health literacy

Individual health literacy is the knowledge, motivation, skills and capacity of a person to access, understand, appraise and apply information to make effective decisions about health and health care, and make appropriate decisions.

The health literacy environment is the infrastructure, policies, processes, materials, people and relationships that have an impact on the way in which people access, understand, appraise and apply health-related information and service.

Patient

A person receiving medical services because of a problem or a check-up

deBronkart D (2013). ‘Let patients help’: A “patient engagement” handbook-how doctors, nurses, patients and caregivers can partner for better care’ epatientdave.com/let-patients-help/
COMMENTS AND RECOMMENDATIONS

1. Accreditation of health professionals is a key component of **safe, quality health care**.

2. Consumers and communities (who fund and are the reason for accreditation) expect an accreditation system that is **evidence-informed and efficient, and prioritises safety and quality** over professional identify, ego and political positioning.

3. Training and associated competencies required for registration must encompass consumer and community perspectives on **quality** and **value**.

4. The 2017 OECD report: ‘Caring for quality in health’ identifies, in part, the **centrality to quality** of safety, effectiveness, patient-centredness, monitoring of patient reported outcomes and transparency.

5. The 2014 Health Foundation report: ‘Person-centred care from ideas to action’ describes how health care would reflect a **person-centred approach to value**: ‘we would start by understanding what matters to the patient. Every encounter would be one which embraces the patient as person rather than object. We would explore their health beliefs, motivations, knowledge, skills, learning styles and familial and social context as well as according to their disease and demography. Interventions would be targeted and tailored based on these insights to support people where they are at to achieve their goals. [And we would measure: How far people’s preferences are supported; how confident and able people are to manage their long-term conditions better; the extent to which the NHS has been successful, working in partnership with others such as social care, housing and the voluntary sector, supporting people to achieve their outcomes.’

6. Consumer and community perspectives must be **integral to every aspect of the accreditation process**: setting standards, assessing quality, managing risk and operating with transparency and accountability to the community and the taxpayer. This could be achieved by ensuring:
   
   a. Trained consumer representatives (at least two) are members of all key committees and groups at the governance and operational level.
   
   b. The chairs of all key committees and groups are informed about and required to demonstrate inclusion of consumer evidence and influence in their work.
c. Committee and group members are informed about consumer evidence and representation relevant to their terms of reference and share accountability for these

d. There are trained consumer surveyors in all assessment panels

e. All surveyors have consumer evidence included in their training

f. Surveyor training encompasses consumer evidence and perspectives and the role of patients as teachers

g. The Consumer Reference Group or similar includes in its scope (and resources) induction in consumer engagement for consumer representatives and chairpersons and collegiate and other support for consumer representatives active across the accreditation structures and processes.

7. Accreditation processes and their intent and impact must be accessible to consumer representatives/organisations and the wider community. This means, in part:

a. Standards are, wherever possible, common to the professions and explained in simple terms to enable the community to understand rights, responsibilities, expectations and accountability. These include standards related to person and community-centredness and social and cultural inclusion.

b. Technical/craft-specific standards are identified and retained for each profession and separate from the universal standards only where they are unique to a profession or group of professions.

c. Information must be clear about what it does not encompass, including which health providers are not registered and regulated and why and what this means for consumers

d. Routine monitoring and review of standards is informed by an analysis of complaints data and a consumer centred risk management approach.

8. Accreditation processes should contribute to creating the workforce the community needs and prefers, now and into the future. This includes:

a. Anticipating and responding to new and emerging consumer- and community-centred service models that focus on what matters to consumers: achieving safety, wellness and quality of life

b. Training and placements that encompass the place-or setting-based competencies including different levels and contexts of care and diverse communities and locations

c. Evidence-informed and representative consumer input.
9. Consumers **expect health professionals to work together to achieve consumers’ health and wellbeing goals.** Health professionals should be competent not only in their ‘craft’: they should also be competent to work in partnership with consumers and other health and social care services to meet consumers’ and communities’ needs. This requires competencies related to working in partnership with consumers; as a member of a team; and with cultural insight and respect – as well as clinical, communication and research and translation competencies.

10. Consumers expect the **environments in which health professionals work to support best evidence and outcomes.** Training and hence accreditation should encompass the National Safety and Quality Standards and the competencies professionals require to meet these, including Standard 1: Governance and Standard 2: Partnering with Consumers.