

NATIONAL ACCREDITATION HANDBOOK

**Endorsed by the Australian Screening Advisory Committee
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LIST OF ACRONYMS

AHMAC	Australian Health Ministers' Advisory Council
ASAC	Australian Screening Advisory Committee
BSA	BreastScreen Australia
NAC	National Advisory Committee
NAS	National Accreditation Standards
NQMC	National Quality Management Committee
SAC	State Accreditation Committee
SCU	State Coordination Unit

GLOSSARY OF TERMS

A Service

Screening and Assessment Service (Service)

Generally, the term “Service” can describe the total of all BreastScreen Australia screening and assessment Services implemented in any State or Territory. The Service is a managing entity that provides comprehensive screening and assessment services for a defined catchment area. It may include various combinations of mobile and relocatable units, as well as providing screening and assessment services from fixed venues. The term is also commonly used to describe a particular venue or geographically based service delivery arrangement. In this handbook, the term “unit” is used to differentiate a component of a Service.

New Service

A Service that is commencing where there has previously been no Service, or a Service that has undergone significant changes such that it does not have 12 months of data illustrating its current structure and activities.

Physical venues for service provision

Mobile unit

A mobile provides screening, or screening and assessment, as part of a particular screening and assessment Service in a variety of locations. A mobile unit could take the form of a truck, bus or van, and is fully self-contained in that all screening occurs on the vehicle.

Relocatable unit

A relocatable provides screening as part of a screening and assessment Service in a variety of fixed sites through the use of a relocatable mammography machine and other equipment transported between facilities. The mammography machine is taken from the vehicle and placed in the fixed venue for a short period of time. Screening does not occur on the vehicle.

Screening unit	A fixed venue that provides screening and possibly assessment Services as part of a particular jurisdiction’s BSA Program. It can be in either the public or private sector.
Unit	A component of a Service (eg. a mobile, relocatable or fixed site that forms part of a specific screening and assessment Service)
Other terms	
Data audit	An independent assessment of whether a Service’s data management practices comply with data management standards and procedures referred to in the data audit guidelines and in the National Accreditation Standards (NAS).
Data standards or data items	The quantitative NAS. These are listed in the data report form.
Full accreditation	Non-provisional accreditation (ie. four year accreditation with commendation, four year accreditation, two year accreditation, two year accreditation with high priority recommendations).
Interim data audit	A scaled-down version of a data audit, applicable in some circumstances.
Interim site visit	A scaled-down version of a site visit, applicable in some circumstances.
NAS annual data report	A report provided annually to the NQMC by Services, outlining performance against the quantitative items of the NAS. This report is not necessarily based on calendar or financial years.
Non-data standards or non-data items	The qualitative NAS. These are listed in Part B of the application for accreditation form.
Pre-commencement visit	A type of site visit undertaken before a new service is established. It is also implemented at the discretion of the SAC, SCU or a service before a new unit is opened. The visit team consists of a minimum of two members of the SAC (and any other members the Service, SCU or SAC require).
Program, the Program	The BreastScreen Australia Program, a national, organised screening program for the early detection of breast cancer.
Program manager	The person in each jurisdiction who is responsible for implementing and managing the range of services and associated policies and practices that make up the entity of BreastScreen Australia within that State or Territory.
Service Manager	The person responsible for the day to day management of a particular Service within a jurisdiction.
Site visit	An external review of a Service, based on the NAS, and undertaken by a team of professional peers.

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1

INTRODUCTION

1.1 BACKGROUND

Accreditation is a means of quality management adopted by the BreastScreen Australia Program through a system of nationally recognised and developed standards and peer review. The accreditation process aims, through independent review, to strengthen and sustain the quality of service provision, proving it worthy of public confidence.

When the Australian Health Ministers' Advisory Council (AHMAC) agreed in 1990 to establish a national mammographic screening program, it stipulated that to ensure high quality, mammography screening and assessment of women with screen detected breast abnormalities should only be performed by Services that are accredited.

Consequently, the National Advisory Committee (NAC) to the National Program for the Early Detection of Breast Cancer (now BreastScreen Australia) and its National Accreditation Committee, now the NQMC, were established by the Commonwealth Minister for Health in 1991. The first National Accreditation Requirements were developed and implemented at the outset of the National Program for the Early Detection of Breast Cancer (now BreastScreen Australia) in that year. These requirements were reviewed and revised in 1994.

The NQMC initiated a second review of the National Accreditation Requirements in 1999. The review involved consultation with the State and Territory BreastScreen Services, consumers and representatives of the disciplines, professions and occupational groups involved in the Program. The resulting National Accreditation Standards (NAS) were endorsed, with amendments, in July 2001 by the NAC, and became operational on 1 July 2002. The NAS are revised and amended by the NQMC as required, under the auspices of the Australian Screening Advisory Committee (ASAC) which has taken on the role of the former BreastScreen Australia NAC.

In February 2003 the NAC endorsed a tool to support accreditation decision-making using the NAS. This tool groups the NAS and enables them to be used in a risk management framework.

The NAS and the Decision Tool are integral to the accreditation process of the Program. They are however, simply tools, and the true success of the Program can be attributed to the

dedication and integrity of the people who use them to maintain and develop the quality of the services provided to women across Australia. The extent to which each BreastScreen Australia Service accepts and fulfils the responsibilities of the accreditation process is a measure of its commitment to excellence in its activities.

The NAS allow for flexibility based on local requirements. Once accredited, BreastScreen Australia Services agree to abide by the standards of the Program, and to self-regulate by taking responsibility for their own improvement within the time period of the accreditation achieved.

Quality management and improvement are ongoing processes, and have evolved along with the BreastScreen Australia Program. The accreditation process will be continually reviewed to ensure its effectiveness is sustained and increased over time, and its objectivity and transparency are developed to best practice standards. Meanwhile, the NQMC is confident that BreastScreen Australia has developed a robust accreditation process that ensures women have access to high quality services across the nation.

The NQMC would like to acknowledge the efforts of Program staff, consumers and external stakeholders in contributing to the development and implementation of the quality improvement process in BreastScreen Australia. Quality in the Program is based on the expertise and input of a wide range of people who undertake coordination, monitoring, data management and auditing, site visiting and provide policy and technical advice. In particular, the NQMC would like to recognise the contribution of those who chair site visit teams, as this is a crucial and demanding role.

1.2 PURPOSE OF THIS HANDBOOK

This handbook outlines the accreditation process and provides a guide to achieving accreditation. Its primary audience is service providers and managers. It also aims to inform all those involved in the accreditation process, including Service staff, site visitors, data auditors and managers and consumers.

The handbook is one of several BreastScreen Australia key accreditation documents including:

- the NAS Decision Tool;
- a suite of forms; and
- a site visitors' training package.

The NQMC has overseen development of this handbook and the related products in close consultation with stakeholders. Copies of materials related to accreditation will be available from the Australian Government Department of Health and Ageing Website: <http://www.breastscreen.info.au>

1.3 AN OVERVIEW OF THE ACCREDITATION PROCESS

To achieve accreditation a Service needs to demonstrate to the NQMC, as the accreditation decision making body, that it meets the NAS to an acceptable level. The accreditation system is tiered, with various levels of accreditation attainable, as outlined in Section 3.

The accreditation process includes:

- provision of data on all of the NAS by the Service (in annual data reports and through a data audit);
- self-assessment by the Service;
- a site visit and subsequent report;
- any response from the Service to issues raised;
- recommendation to the NQMC by the State Accreditation Committee (SAC); and
- consideration and subsequent accreditation decision by the NQMC.

State Coordination Units (SCU) work with Services to ensure they meet the NAS and to organise accreditation activities. A Service's approach to accreditation should be integrated into its overall quality improvement program. Detailed steps in the accreditation process are outlined in Section 4.

1.4 TIMEFRAMES AND PROCEDURES—MANDATORY OR DISCRETIONARY?

This handbook sets out operational policy for implementation of the accreditation process within the BreastScreen Australia Program. Each State and Territory is responsible for implementing BreastScreen Australia Services consistently with national policies. However, each jurisdiction provides a different context for service delivery, through variables including demographics, distance, and infrastructure. Therefore there is some scope for the requirements set out in this handbook to be met in a manner most appropriate to local needs. Appendix A outlines an example of a flexible approach to achieving accreditation.

While the NQMC has made recommendations for implementation of accreditation processes based on what it considers best practice, it cannot enforce these. However, the quality and timeliness of the material provided to NQMC will affect its accreditation decision making.

The timeframes in this document are strongly recommended by the NQMC as they have been determined to give Services the best possible opportunity to achieve accreditation. In considering any changes to recommended procedure, each jurisdiction should ensure that the intent of the procedure outlined in the handbook is met, and that it does not jeopardise a Service's accreditation process nor impose any difficulties upon stakeholders, including site visitors, data auditors and clients. For instance, the provision of materials to site visitors and data auditors three weeks before a site visit or data audit is considered the necessary minimum time to enable full consideration of materials before the event. This will support best use of experts' time on site and best use of Service resources. It is also a courtesy and is congruent with the requirements of similar international programs.

2

THE NATIONAL ACCREDITATION STANDARDS AND THE DECISION TOOL— A RISK MANAGEMENT APPROACH

2.1 AN OVERVIEW

There are 177 NAS against which performance is measured. The NAS are sometimes referred to as data and non-data standards or items. This reflects that some are quantitative, and can therefore be reported against in the data reports required of Services, while others are qualitative in nature.

To improve decision making against the NAS, a Decision Tool was developed. Within the Decision Tool the standards are grouped together into the following clusters to better support balanced assessment of performance.

- Assessment
- Cancer detection
- Continuity, counselling and support
- Data management
- Equitable access
- Information given
- Management
- Participation
- Timeliness
- Unnecessary recall

These ten clusters represent the key performance objectives of BreastScreen Australia as a national program, and are all equally important. While some standards could be grouped under more than one cluster, each is allocated only to the most relevant cluster in the interests of simplicity.

The Decision Tool employs a risk management approach to decision-making. Risk management is a well recognised, objective way to provide a structure without sacrificing flexibility. It also has the advantage of enabling the use of a system of tiered accreditation. As well as being a practical approach, it accords with emerging best practice¹.

Each NAS has been allocated a risk rating, allowing for consideration of the impact of not meeting that standard on the key outcome areas. The allocation of risk ratings does not mean that some standards are more important, as all the NAS are important for ensuring quality of service. Risk categorisation is simply a method of assessing the impact of a Service performing poorly against a NAS.

¹ Guidelines for Managing Risk in HealthCare HB 228:2001: Australian and New Zealand Handbook Standards Australia & Standards New Zealand

The level of risk allocated to each standard describes the combined effect of likelihood and consequence. It also indicates what level of treatment action might be required, and who should be responsible for treatment action. So while the Decision Tool is primarily a tool for accreditation decisions made by the NQMC, it also has immediate practical value in supporting Service Managers to make Service delivery decisions and to manage poor performance.

To ensure transparency of NQMC accreditation decisions, the Decision Tool is available to all involved in the accreditation process. Understanding the tool can assist Services in their preparation for the various accreditation activities.

The following matrix was used to determine the level of risk to be allocated to each standard. The seven risk categories are severe, high, major, significant, moderate, low and very low.

Table 1: Matrix used to determine the level of risk allocated to each standard

	Consequences				
	extreme	very high	medium	low	negligible
almost certain	severe	severe	high	major	significant
likely	severe	high	major	significant	moderate
moderate	high	major	significant	moderate	low
unlikely	major	significant	moderate	low	very low
rare	significant	moderate	low	very low	very low

To streamline the decision-making process and to support a strategy for managing gaps in performance, the seven risk categories are grouped into three levels. These are:

- **level 1** severe and high risk;
- **level 2** major and significant risk; and
- **level 3** moderate, low and very low risk.

The number of standards per risk level of each cluster of standards is shown below.

Table 2: Summary of the number of standards per risk level per cluster

Cluster	Ranking of standards by risk level		
	Level 1 (severe/high)	Level 2 (major/ significant)	Level 3 (moderate/low/ very low)
Assessment	4	13	5
Cancer detection	7	15	5
Continuity, counselling & support	-	8	5
Data management	-	11	4
Equitable access	-	5	-
Information given	-	8	2
Management	2	46	5
Participation	-	6	4
Timeliness	1	8	1
Unnecessary recall	-	7	1
TOTALS	14	127	32

3

LEVELS OF ACCREDITATION—A TIERED SYSTEM

3.1 THE FIVE LEVELS OF ACCREDITATION

There are various levels of accreditation an existing Service can attain, with various time periods applying. Non-accreditation is also possible, and a new Service comes into the Program at the provisional level of accreditation.

Table 3: Accreditation levels

Accreditation level	Achieved standard
Four year accreditation with commendation	Service performs highly against all standards.
Four year accreditation	Service performs well against most standards, including all level 1 standards.
Two year accreditation	Service meets all level 1 standards but not a significant proportion of level 2 and 3 standards.
Two year accreditation with high priority recommendations	Service meets the requirements for a two year accreditation term other than meeting a number of level 1 standards.
Provisional accreditation	Two years provisional accreditation for new services.
Non-accreditation	Service does not meet requirements for accreditation for 2 year accreditation with high priority recommendations, or accreditation has lapsed.

3.2 HOW THE LEVELS OF ACCREDITATION RELATE TO THE NATIONAL ACCREDITATION STANDARDS

In making an accreditation decision, the NQMC considers the balance of a Service’s performance across all ten clusters of standards, guided by the requirements set out in Table 4 below.

Table 4: Required levels of performance for each tier of accreditation

Accreditation level	Required performance level against National Accreditation Standards
Four year accreditation with commendation	Must meet all standards in all clusters.
Four year accreditation	Overall Service must meet at least 89% of the NAS; and 100% of all level 1 standards; 90% of all level 2 standards; and 80% of all level 3 standards.
Two year accreditation	Overall Service must meet at least 80% of the NAS; and 100% of all level 1 standards; 80% of all level 2 standards; and 70% of all level 3 standards.
Two year accreditation with high priority recommendations	Overall Service must meet at least 79% of the NAS; and 90% of all level 1 standards; 80% of all level 2 standards; and 70% of all level 3 standards.
Provisional accreditation	Entry level for new Services.
Non-accreditation	Where Service does not meet at least the requirements for accreditation for 2 year accreditation with high priority recommendations, or where accreditation has lapsed.

While accreditation decisions are solidly based on the Decision Tool, the decision making process is more complex than a simple “yes or no” approach to compliance with the NAS. The NQMC considers the overall context of a Service’s performance, including previous performance, trends, data in related performance measures, quality improvement strategies that have been implemented, progress made, and any other information provided. The BreastScreen Australia accreditation system, rather than being a direct compliance audit, is a flexible, comprehensive and multi-disciplinary method for assessing quality from various perspectives.

It is therefore critical that Services provide as much information as possible to allow the NQMC to review all of the data in context. The NQMC considers the findings of the site visit team and State Accreditation Committee (SAC) when making a decision. Its final decision is guided by the Decision Tool, and is based on all of the information and data presented as well as the multidisciplinary and expert discussions held at its meetings. This results in a quality improvement rather than an audit process.

For instance, on some occasions, a performance measure may fall short of the NAS, but lie within the 95% confidence interval. There would be grounds in these circumstances for considering whether this was due to chance. Therefore it is in the interest of Services to report against confidence intervals wherever possible in addressing standards that are technically unmet and just on the borderline of being met. Services should also provide any information available to support consideration of the NAS as being met, such as aggregated data that can increase interpretive power or show trends.

This is particularly critical in the case of Services screening or assessing small numbers of women, where performance is more likely to vary from the NAS as a result of chance. To assist Services to assess whether their performance truly differs from the NAS or differs as a result of chance, funnel plots have been developed and included in the NAS document.

Where performance is below the absolute target set by the standard, but within the confidence interval, close monitoring should be implemented. It is recognised that not all Services will meet all of the NAS. If a Service is not achieving a standard, the reasons should be analysed and targeted strategies for improvement implemented. The NQMC will consider accrediting Services that do not meet a standard based on the reasons provided for not meeting the standard, demonstration of quality improvement processes and targeted strategies for improvement, and trend data to indicate that performance is improving over time.

3.3 CATEGORISING PERFORMANCE AGAINST INDIVIDUAL STANDARDS

There are four ways in which a Service's performance can be categorised against a national accreditation standard. The standard can be considered to be:

- met;
- unmet;
- met with exception; and
- unable to be assessed.

Met and unmet

The first two categories, “met” and “unmet” are applicable in situations where there is enough sound information and evidence available to determine that a Service clearly does or does not meet the required performance level required for a particular NAS. These two categories will be the most frequently applied in documentation provided to the NQMC.

Met with exception

This category is likely to be most relevant in classifying performance against some quantitative standards. To fit in this category, performance against a NAS must be very close to meeting the absolute standard. For example, ninety nine percent of women met the standard instead of all women. Explanatory information must be provided as well as information on the strategies in place to enable the standard to be met.

The “met with exception” category can only be applied to a limited number of NAS. These are:

- 2.12.3** All film readers read at least 2,000 mammographic screening cases within the Program per year.
- 2.21.2** All women with impalpable lesions undergoing open biopsy have specimen radiography performed.
- 2.24.2** All surgical histopathology and primary treatment information is requested by the Service.
- 3.5.4** All staff attend at least one cultural awareness training course.
- 3.8.2** All women are notified of the results of their screening in writing, within 28 calendar days of the date of screening.
- 3.8.4** All women receive the results of FNA biopsy and core biopsy within 14 calendar days of the assessment procedure.
- 3.8.5** All histological and cytological results are given by a clinical member of the assessment team.
- 3.8.6** All women are notified of the results of their assessment in writing, within 14 calendar days of the date of completion of assessment.
- 3.9.1** All women diagnosed with breast cancer are told their results by a clinician in accord with the recommendations in Appendix U and with a member of staff responsible for providing counselling present, unless the woman specifically asks them not to be.
- 3.9.2** All women diagnosed with breast cancer are:
 - provided with the consumer guide based on NHMRC clinical practice guidelines;
 - encouraged to discuss options with their clinician.
- 3.10.1** All women who attend for screening and their support persons have access to counselling.
- 3.10.2** All women who attend for assessment or to receive pathology results and their support persons have access to counselling on site.

- 3.10.4** All counselling is provided by staff who have specialist knowledge of breast screening and assessment and relevant counselling skills and training.
- 3.10.5** All staff who provide counselling have access to professional support provided by an appropriate counsellor.
- 3.11.1** All women screened are asked to nominate a general practitioner to whom their results will be forwarded.
- 3.11.2** All women recalled for assessment are asked to confirm or nominate a general practitioner to whom their results will be forwarded.
- 4.3.1** All new and existing staff meet the relevant expertise, experience and training standards outlined in Appendix J.
- 4.3.2** All professional staff undertake continuing education and meet the continuing medical requirements of the professional bodies which represent their discipline.
- 4.3.4** All staff receive appropriate orientation and training within three months of commencement of employment at the Service.
- 4.3.6** All staff undergo annual performance appraisal, where they have the opportunity to identify any training needs that have not been met and agree to a plan for addressing these needs.
- 4.6.3** All staff are trained to ensure an understanding of the policies, protocols and procedures of the Service.
- 4.9.1** All screening units within the Service are linked to a specific assessment centre.
- 4.11.2** All staff sign a confidentiality form outlining their responsibilities and obligations upon commencement of employment at the Service and each year thereafter.
- 4.11.4** All client records are securely stored, using an accepted method of medical-record filing, and access is restricted to appropriate persons only.
- 4.12.6** All paper clinical records held by all units in the Service are dated and identifiable to the relevant health professional for that part of the screening and/or assessment pathway.
- 4.12.8** All relevant staff are instructed in procedures to ensure quality of data at all levels of the screening and assessment pathway.

Unable to be assessed

This category applies in situations where there is not enough data or evidence available to make an informed calculation on whether or not a NAS has been met. For example, a new Service may not have been operating long enough to collect enough data to measure its performance against particular NAS.

3.4 WHAT DO THE DIFFERENT LEVELS OF ACCREDITATION MEAN FOR SERVICES?

Accreditation provides an objective assessment of a Service's performance and feedback on quality improvement. This information can be incorporated into the Service's quality improvement program to effect positive change. Accreditation is also a way of acknowledging excellence in Service provision.

The NQMC expects all Services to implement continuous quality improvement programs that are complementary to and consistent with the requirements of the BreastScreen Australia accreditation process. Accreditation is a continuous improvement process that does not stop on achievement of a level of accreditation. The NQMC, and the SAC/SCU, through annual data reports and exception reports monitor Service performance. The NQMC can revise accreditation status at any time in the accreditation cycle.

All Services achieving accreditation receive a certificate from the NQMC Secretariat acknowledging their success. A Service achieving four year accreditation with commendation will receive an additional certificate in recognition of this outstanding result.

Certificates must be displayed by Services in a prominent position where they can be seen by consumers. Additional information explaining the levels of accreditation must be available to consumers.

What happens when a Service achieves four year accreditation?

A Service achieving four year accreditation with commendation is exemplary and should aim to continue operating to its current level of achievement.

Four year accreditation indicates that while the key NAS are being met, as are the majority of NAS overall, there is some room for improvement. A Service achieving this standard is encouraged to maintain its current achievements and to make improvements where possible.

Four-year accreditation is the longest period available within the system.

What happens when a Service achieves two year accreditation?

Prior to the end of the two year period, a Service accredited at this level may request either:

- a review of performance against the unmet standards for a further two years accreditation (at the discretion of the SAC this may be a detailed report including a complete updated data report or an interim site visit); or
- an accreditation review to be assessed for a four year accreditation term.

The Service should inform the SAC of its review proposal at least six months prior to the end of the accreditation term. The SAC should then inform the NQMC of the requirement for the Service.

A Service CANNOT opt for an interim site visit more than once. A Service must have a full site visit at least once every four years.

What happens when a Service achieves a two year accreditation with high priority recommendations?

The Service will be required to provide detailed 12-monthly reports to the NQMC. This will include the same data component as the annual data report plus a specific section addressing the high priority recommendations and any other areas of concern raised in the accreditation process. Trend data reports are also to be provided. The NQMC may also request additional interim reports. The Service is expected to take action to address the issues raised, seeking support and guidance from the SCU and the SAC.

Prior to the end of the two year period, a Service accredited at this level may request either:

- a review of performance against the areas with high priority recommendations and any unmet standards for a further two years accreditation. This should be done through an interim site visit with NQMC agreement (see Section 4.5); or
- a full accreditation review to be assessed for a four year accreditation term.

Note that a Service must have a full site visit at least once every four years. It is not acceptable for any Service to have two consecutive interim site visits for accreditation purposes.

The Service should inform the SAC of its review proposal at least six months prior to the end of the accreditation term, and the SAC will request agreement from the NQMC for an interim site visit if required.

While it is possible that a Service could keep attaining two year accreditation with high priority recommendations indefinitely, this is not ideal.

Services with two year accreditation with high priority recommendations are not eligible to apply for extensions of accreditation.

What happens when a Service achieves provisional accreditation?

Provisional accreditation exists to allow new Services to become operational and to develop the potential to achieve full accreditation within the BreastScreen Australia Program. Services that have become non-accredited also use provisional accreditation to re-enter the Program.

Once a Service has achieved provisional accreditation, it has two years in which to become established and to collect data to support its application for full accreditation. Note that Services with provisional accreditation are likely to proceed to two rather than four year accreditation, as they will not have sufficient data at the end of their provisional accreditation period to demonstrate that they meet all the NAS.

Before the end of the provisional accreditation period, the Service Manager should commence work with the SCU and SAC to apply for full accreditation.

3.5 IMPLICATIONS FOR SERVICES OF NON-ACCREDITATION

A Service that is not accredited due to its inability to meet the requirements for two year accreditation with high priority recommendations will not be able to:

- operate as a BreastScreen Australia Service; and
- use the BreastScreen Australia logo or any logo or material that identifies it with the Program, including State and Territory versions of the logo.

A non-accredited Service should in no way purport to be part of the BreastScreen Australia Program. The accreditation process is evidence of BreastScreen Australia's commitment to quality services. The operation of non-accredited Services seemingly under the Program's auspices may undermine the integrity of the Program, and most importantly, potentially put clients and staff at risk.

A Service in this situation should undertake careful risk management planning with the relevant State or Territory Program Manager to make informed decisions about whether to continue operations. The Program Manager should make informed decisions with their health authority as there will be medico-legal and funding implications to consider.

Should a non-accredited Service re-apply for accreditation, it will do so at the provisional level. Any data provided in support of an application for accreditation is to apply to the relevant period—that is, from the time the Service instigates its application for accreditation and in effect, commences as a new Service. Data pertaining to periods before the Service's application for provisional accreditation is not relevant on the basis that it relates to the previous structure and operations which would be expected to have changed significantly to address the reasons for non-accreditation.

Services that allow their accreditation to lapse become non-accredited. See Section 5.7.

3.6 ACCREDITATION DECISION-MAKING—AUTHORITY AND TRANSPARENCY

The authority for decision-making regarding the accreditation of individual BreastScreen Australia Services rests with the NQMC. The NQMC may vary from the requirements set out in Table 4 provided there is sufficient justification. In any such cases, the NQMC's reasons will be fully documented by the NQMC secretariat and communicated in writing to the relevant SAC. There is an appeals process for NQMC decisions, outlined in Section 10.

As it is a government committee bound by Commonwealth administrative law provisions, NQMC deliberations and decisions may be subject to external reviews, such as by the Commonwealth Administrative Appeals Tribunal, the Australian National Audit Office, and the Commonwealth Ombudsman. The NQMC may also be answerable to Freedom of Information requests, Administrative Decisions (Judicial Review) legislation and Parliamentary inquiry. Therefore, care is taken to properly record the deliberations and decisions of the NQMC.

4

KEY COMPONENTS OF THE ACCREDITATION PROCESS

4.1 COLLABORATION WITH THE STATE ACCREDITATION COMMITTEE AND THE STATE COORDINATION UNIT

The State Accreditation Committee (SAC)

The SAC is appointed by the jurisdiction and is independent of the NQMC. Its role is to oversee accreditation activities within its State or Territory and to work with members of the SCU and with service providers to support the provision of quality services within BreastScreen Australia.

For those States and Territories where there is more than one Service, the SAC develops a jurisdictional annual plan for spacing accreditation against which Services can align their accreditation needs. This annual plan also informs NQMC when considering requests for extension, and allows the NQMC secretariat to plan for the related workload for data auditors, site visitors and the NQMC. This plan takes into account the quarterly meetings of NQMC, which usually occur in February, May, August and November. This meeting schedule is important for jurisdictions and Services to consider when planning their accreditation processes.

The SAC notifies NQMC if accreditation timeframes are unable to be met, and liaises with the SCU and the NQMC. It also makes recommendations to the NQMC on the accreditation of Services. The NQMC does not consider accreditation applications without a recommendation from the relevant SAC.

Members of the SAC undertake pre-commencement visits to new Services, and to new units where appropriate, to ensure they have the capacity to operate according to the NAS. The SAC ensures a quality improvement plan is implemented where Services have not fulfilled all requirements in the first instance.

The SAC ensures all accreditation documentation submitted to the NQMC is in line with the NQMC requirements and is completed. A covering letter to the NQMC, signed by the chair of the SAC, is included with the final SAC accreditation recommendation.

The SAC is a jurisdictional committee, and the relevant State or Territory determines its members. It is recommended that membership of the SAC include representation from

the appropriate clinical and non-clinical disciplines including epidemiology, consumer representation, and a non-voting representative from the SCU. It is also recommended that at least one of the members have site visit experience, and that members undertake the site visitor training program.

Not all States and Territories have established a SAC. In these instances, it is strongly recommended that the SAC of another jurisdiction perform the role.

Services generally do not deal directly with the SAC but rather with the SCU. All accreditation communication (including documentation) from a Service should go through the SCU and then the SAC to NQMC. Similarly, the NQMC communicates to the Service through the SAC. The NQMC secretariat liaises with the SCU as required to contribute to arrangements for data audits and site visits. See Section 14 for further details of the SAC role.

The State Coordination Unit (SCU)

The SCU is responsible for organising accreditation activities within the State or Territory.

This includes:

- providing all relevant documents to the Service to support implementation and measurement of the standards well in advance of the scheduled accreditation process (including the NAS and relevant forms);
- consulting with Services and providing advice on compliance with the NAS;
- applying to the NQMC well before a site visit is due to be arranged should it require an interim rather than full site visit for a Service reaching the end of a period of accreditation at two years with high priority recommendations;
- arranging interim data audits and interim site visits with input from the Secretariat as required;
- notifying the NQMC secretariat of proposed data audit and site visit dates and requesting the selection of a data auditor and formation of a site visit team;
- providing the data auditor with accreditation documentation for consideration no less than three weeks prior to the data audit;
- ensuring a data audit has been undertaken within the six months prior to an application for full accreditation (and two to three months prior to a site visit);
- providing the site visit team with accreditation documentation for consideration, including the data auditor's report, no less than 3 weeks prior to a site visit;
- working with the Service Manager to develop a program prior to the site visit;
- arranging a teleconference or meeting to brief members of the site visit team prior to the site visit and providing papers at least a week prior to the event. Alternatively, the meeting may be held at the beginning of the site visit, in which case it is important to ensure adequate time is factored in to the site visit program;
- ensuring that an assessment clinic will be included in the site visit schedule, preferably on the first day;
- arranging payment of allowances for eligible site visitors and data auditors;

- reviewing all applications, site visit reports and data audit reports and ensuring all necessary documentation is forwarded to the SAC; and
- providing secretariat support to the SAC.

For those jurisdictions where there is a single Service and no SAC, the SCU is responsible for the tasks generally undertaken by the SAC. These include submitting the annual data report to the NQMC and notifying the NQMC secretariat of schedules for upcoming accreditation.

4.2 SELF ASSESSMENT

All Services must undertake self-assessment to inform their own operations and to support their accreditation application. This takes the form of a review of the Service, prior to a scheduled site visit, with documentation of performance against the NAS and consideration of the risks as outlined in the Decision Tool. The application for accreditation form can be used for Service self assessment. Management strategies employed to reduce or remove risks should be documented and periodically reviewed by the Service management and staff.

Service staff undertaking self-assessment should be aware that simply tallying their performance against the NAS using a form may give an overly negative view of their performance, especially if done relatively early in a Service's operational lifetime. This is not to discourage the use of self-assessment, which is strongly recommended by the NQMC as a tool to identify issues as well as achievements. It is important to consider the other factors that NQMC includes in its accreditation decision making to achieve a rounded picture of Service performance. See Section 3.2.

Self-assessment can be helpful when establishing a new Service or unit to ensure it is equipped to meet the NAS. It can assist managers and staff to identify any specific issues that will need to be addressed through the Service's own quality assurance program or the accreditation process.

Apart from meeting accreditation requirements, it is strongly recommended that self-assessment be used at any time as a tool to support Service quality.

4.3 ANNUAL DATA REPORTS

The NQMC requires annual data reports from Services. These reports inform the accreditation process and allow the NQMC to monitor performance between accreditation periods. The reports contain information on all the quantitative components of the NAS. An example of an annual data report is at Appendix B for information.

The NQMC requires that all annual data reports include the following:

- actual numbers as well as percentages to assist in interpretation;
- reporting of confidence intervals where indicated;
- bolding of all unmet standards to aid identification;
- inclusion of comments/explanations for all unmet standards; and
- presentation of previous data by comparable time period/s to allow for an examination of trends over time.

Reports should include a clear indication of all unmet standards and where they fall in the funnel plots, if appropriate, as well as a quality improvement plan to describe strategies in place to address unmet standards.

Annual data reports must include information for **each** of the quantitative NAS.

Applications for accreditation should include numerators, denominators and confidence intervals for each of the relevant NAS to aid in interpretation.

The SCU sends annual data reports to the SAC for information and comment before forwarding to the NQMC. The timing of provision of the reports (ie. which month) is at the discretion of the SCU, in consultation with SAC.

Annual data reports are not necessarily based on either calendar or financial years but are provided to the NQMC on an annual basis. Their timing can be established from the data period used in a Service's original accreditation application, with subsequent reports following on 12 monthly from this time.

Note that annual data reports must be provided to the site visit team before a site visit.

4.4 DATA AUDIT

An independent data audit must be conducted within the six months prior to an accreditation site visit, and where possible, two to three months prior to the site visit. While Services with two years accreditation reapplying for the same time period of accreditation are not required to undertake a data audit before every application (see Section 5.4), they must do so at least once every four years. A two yearly data audit is required if there are concerns about data processes and issues. In addition, the Service, SAC/SCU and/or NQMC are entitled to instigate a data audit at any time there is reason. The purpose of the data audit is to assess whether data management practices comply with data management standards and procedures referred to in the data audit guidelines and in the NAS.

The objectives of the data audit are to:

- examine the data management systems and procedures that are currently in place;
- evaluate the accuracy, completeness, security, timeliness and accessibility of data;
- ensure consistency of data management, analysis and reporting procedures;
- provide a report identifying areas which may warrant further attention, including those requiring immediate action and less urgent improvements. The report will also identify those areas which are assessed as meeting data audit standards; and
- recommend any changes in procedures required to ensure the currency, integrity and security of data.

An interim data audit

This is a scaled-down version of a full data audit and may be used as follows.

- To assess the capacity of a new Service or unit to collect data according to BreastScreen Australia requirements.
- As part of follow-up action, for example, if a Service was not meeting some NAS in the period between accreditation reviews. The SAC and/or SCU can recommend an interim data audit as part of a management plan submitted to NQMC in the case of a poorly performing Service.
- When initiated by a Service to inform it of its performance.
- For any other reason the SAC or the NQMC believe it is appropriate.

The use of an interim data audit is at the discretion of the SAC in the first instance, and then the NQMC. Decisions to implement an interim data audit can be based on criteria such as, in the case of a new Service, the anticipated throughput, or in the case of under-performing Services or those with high priority recommendations, the number and category of NAS not being met, and the related risks. For further information, see Section 6.4.

4.5 SITE VISIT

A site visit is an external review of a Service based on the NAS, and undertaken by a team of professional peers. The site visit aims to inform and guide quality improvement within BreastScreen Australia Services. The purpose of the site visit is to assess compliance with the NAS.

The objectives of the site visit are to:

- evaluate the effectiveness and quality of service provision against the NAS;
- examine the quality management systems and procedures that are in place;
- identify any changes in procedures required to ensure the improved quality management;
- provide a report to the Service, SCU, SAC and the NQMC identifying areas which may warrant further attention, both urgently and otherwise;
- identify those areas that are assessed as meeting the NAS; and
- acknowledge where a Service has achieved exceptional performance and/or made significant improvements.

A full site visit is a thorough process, usually taking between two and three days to complete. More information on site visits is in Section 7.

The SAC uses its discretion to determine on a case by case basis the type of site visit required. It considers the potential risks involved and any advantages/disadvantages in having a full or interim site visit. A Service or SCU can also instigate an interim site visit. See Section 7.4.

An interim site visit

Scope of the interim site visit

An interim site visit is considered to be a scaled-down version of a full site visit in that it can but does not have to include a visit to all units of a service. As a result, it may take less time to complete (for instance, less than a full day depending upon the issues to be investigated). Whether or not all units are visited will depend on issues specific to the Service, and the onus is on the SAC/SCU to determine the scope of the site visit in the overall context of supporting quality outcomes.

As a minimum, the interim site visit team should assess all high priority NAS identified by the NQMC and associated standards in that cluster. Emerging issues or issues apparent from the routinely submitted annual data reports identified by the SCU, SAC or NQMC may also be assessed.

Documentation for the interim site visit team should include the high priority recommendations from the NQMC (for Services with two years with high priority accreditation), the previous site visit report and a complete updated data report (and non data report if identified in the high priority recommendations).

Membership of the interim site visit team

The minimum number of team members is two. There is no upper limit on the numbers of visitors who can form an interim site visit team. However, at least 50 percent of the team must consist of visitors external to the jurisdiction¹ of the Service.

This team composition applies only to an interim site visit. A full site visit team has no members from the Service's jurisdiction.

Requesting an interim site visit

The SAC/SCU must write to the NQMC seeking agreement to an interim site visit at least 6 months before the end of the Service's accreditation period. The timeframe will allow for organisation of an interim site visit team, or a full site visit team should the NQMC decide this is necessary.

The letter from the SAC/SCU should present a case for why the proposed interim site visit team is considered appropriate. This should include (but not be limited to) information on the expected composition of the team and how this relates to the HPR and other issues.

The information presented should enable the NQMC to determine that the interim site visit planned is appropriate and that outcomes would not be bettered by having a full site visit or different team composition.

¹ For the purposes of the National Accreditation Handbook a jurisdiction is defined as a State or Territory.

Examples of when an interim site visit may be used include the following.

- A Service achieves two year accreditation with high priority recommendations and then makes relevant changes. It may then apply to the NQMC for an interim site visit aimed at achieving a further two years accreditation. Note that a Service must have a full site visit at least once every four years. It is not acceptable for any Service to have two consecutive interim site visits for accreditation purposes.
- A new unit is added to a Service. See Section 5.3 for further information.
- An accredited Service is experiencing problems in maintaining the quality of service commensurate with its accreditation level.
- A Service is unable to arrange for all units to be made available or accessed at the time of the full site visit, and implements an interim site visit of one or more units at an earlier time (as close as possible to the time of the scheduled site visit). Documentation should then be made available to the full site visit team. This may be a useful option for Services in remote areas, where some units may be difficult to access within the timeframe of a site visit. This option is to be used only in exceptional circumstances and must be supported by written advice from the SAC to the NQMC of the reasons for using the interim site visit. This advice can be included in the covering letter for the accreditation application. It is expected that Services take into account the timing of site visits in their planning and ensure relocatables and/or mobiles are available to be examined at the same time as the fixed venues. (Section 7.4 outlines other options available for relocatables and mobiles).

Where an interim site visit of a specific unit is made in the latter case (above), it is the responsibility of the SCU to ensure the visit is held as close as possible to the time of the full site visit to the rest of the Service. Note that the site visit team must visit any new unit that has not had an interim site visit within the 12 months prior to the end date of the Service's accreditation period. Documentation must be provided to the site visit team, and every effort made to inform the team as fully as possible.

4.6 FORMS

A suite of forms has been developed to support the accreditation process. These will be provided to the SCU in each State and Territory for distribution to Services.

The package includes forms for:

- notification of commencement of Service;
- application for accreditation. This includes sections for contact and descriptive details of the Service and units, reporting against the non data (qualitative) standards for self assessment and use by the site visit team, reporting against data (quantitative) standards for use by the data manager, and for the Service's response to any unmet standards;
- data audit report;
- site visit report;
- request for extension of accreditation;
- response by Service to areas of concern for high priority recommendations;
- appeal application;
- annual data report; and
- deed poll—confidentiality and conflict of interest undertaking (for use by data auditors, site visitors, members of any appeals committee).

It is mandatory for Services to use the new forms as they have been designed to provide the NQMC with information essential to making accreditation decisions, and to assist Services in their self-assessment and the overall accreditation process. The forms are designed for use both electronically and in hard copy. Use of the electronic version of the forms is strongly recommended as they have in-built capabilities such as automatic prompts, calculations and data generation to benefit users.

5

ACHIEVING ACCREDITATION— SERVICE ACTIVITIES

5.1 INTRODUCTION

This section summarises the key components of accreditation and outlines the steps for achieving accreditation for Services in each of the three situations:

- new Services (including those who have lost accreditation and are re-applying);
- new units within accredited Services; and
- already accredited Services (provisional or otherwise) seeking re-accreditation.

While some of the steps are the same, the process has been detailed for each situation so users of this handbook can refer directly to the section that relates to their requirement at the time.

The timeframes given are considered by the NQMC to be reasonable and were determined with the goal of supporting SACs, SCUs and Services to organise their accreditation activities and submit documentation to NQMC in a manner most likely to support a successful outcome. Commencing activities such as organisation of data audits and site visits earlier than the timeframes provided is an option Services may want to take up at their discretion. However, it is recommended not to undertake activities later than suggested as this could adversely impact on critical steps within the process. As a new period of accreditation is calculated to commence from the time accreditation would have expired, and not the date of the site visit or any other specific activity, Services that organise their accreditation activities early are not penalised.

5.2 SEEKING PROVISIONAL ACCREDITATION—STEPS FOR A NEW SERVICE

Work with the SCU to become established as a new Service

A month prior to a new Service commencing screening, it must notify the SCU, using a notification of commencement form.

The SCU ensures that a pre-commencement visit is undertaken by a minimum of two members of the SAC (and any other members the Service, SCU or SAC require). The Service Manager and a SAC member then finalise the notification of commencement form, which includes a report on all non-data items.

The SCU forwards the notification of commencement form to the SAC, with any additional information in support of the Service becoming provisionally accredited, such as notification of date for interim data audit. The SAC provides this to the NQMC secretariat with its recommendation that the Service be provisionally accredited.

The NQMC secretariat will advise the SAC in writing of provisional accreditation being approved.

Familiarise staff with the NAS, the accreditation process and supporting documents

The SCU can assist in outlining the accreditation process to heads of Service and staff. The Service Manager can work to ensure general quality improvement processes are in line with NQMC requirements. Staff should be aware of the principles of accreditation and quality improvement, and have access to the NAS and related documents.

The SCU provides the application for accreditation form to the Service. The self assessment component of this form can be used at any time by the Service Manager and staff to assist in quality management, although it will need to be updated before the Service applies for full accreditation.

Arrange with the SCU for an interim data audit

The SCU arranges an interim data audit of the new Service upon commencement, liaising with the NQMC secretariat as required. The purpose of this audit is to ensure that required data management processes are in place and that the Service has the capacity to collect the necessary data.

The data auditor will provide the SCU with a report within two weeks of the audit. This report will outline whether the Service is satisfactory or not in demonstrating its capacity to collect and manage the required data, and may give recommendations.

A copy of the interim data report is forwarded to the SCU, which will provide it to the Service for information and action as required. The report should be attached to the Service's application for accreditation.

Collaborate with the SCU on accreditation planning

The Service consults with the SCU to develop a timetable for accreditation that fits in with the SAC annual plan and the NQMC quarterly meeting schedule. This includes determining when to best schedule in the arrangement and execution of the data audit and site visit.

Operate according to NAS

For the 24 months of the provisional accreditation period, the Service is expected to operate according to the NAS and to collect data to support its application for full accreditation.

Make an application for accreditation

The Service should commence its application for full accreditation no later than after 16 months of operations. This allows eight months for the process to be completed, bringing the Service up to the end of its two year period of provisional accreditation.

The application for accreditation form is completed and provided to the SCU with copies of supporting documentation (eg. organisational chart, management structure, and organisation profile, interim data audit report).

The SCU provides the form to the data auditor for completion of the data component. After this, the SCU provides the form to the site visit team for their input. The site visit team uses the form as the basis of their report to the NQMC. The completed form remains with the SCU, which provides the Service with a copy of all subsequent components as they are received (eg. the data audit and site visit reports).

Undergo a data audit

The SCU arranges with the NQMC secretariat for a data audit. The data auditor provides a report to the SCU within two weeks of the audit taking place. The SCU forwards a copy to the Service Manager and retains the original for provision to the site visit team.

Undergo a site visit

The SCU finalises with the NQMC secretariat arrangements for a site visit to take place after the data audit, at no later than month 20 of operations (ie. approximately four months before the NQMC meeting at which the Service's application is to be considered). The chair of the site visit team forwards the report of the visit to the SAC/SCU within two weeks of the visit, for provision to the Service.

Discuss data audit and site visit reports with the SCU and/or SAC and develop a response if appropriate

The Service Manager, the Program Manager and the SCU may decide to include a response to issues raised in either or both reports. This is provided to the SAC by the SCU for inclusion in the application package of materials to go to NQMC. The SAC assesses the application documentation and provides feedback to the Service as required.

In the event that a self assessment, site visit or any review against performance standards indicates significant problems with the Service, or with any unit or component of the Service, the SAC advises the NQMC of the following:

- the issue/s and reason;
- the action being taken to address deficiencies;
- the time lines for completion of action; and
- if necessary, any expected delay in its accreditation recommendation.

One of the benefits of self-assessment is that it allows Services early notice of problems so that they can work with their SCU and SAC to address these before initiating accreditation proceedings, and before any potential impact upon consumers, staff and other stakeholders is realised. See Section 11 “Using the risk management approach to improve Service performance”.

Because extensions to periods of provisional accreditation are not available, it is critical for Services to work closely with the SCU and/or SAC to ensure that issues that may delay or threaten their application for full accreditation are dealt with immediately they arise. Note that most Services will not comply with all of the NAS and this in itself is not necessarily a reason for delaying a recommendation for accreditation.

The SCU and SAC meet to determine the SAC recommendation to the NQMC. The Service Manager may be included in this meeting.

The SAC provides application documentation to the NQMC

This includes the completed cover sheets of the application form, any attachments the Service wants to include, plus interim and full data audit reports and site visit report, and any Service response to these reports, and the SAC recommendation on accreditation with a covering letter from the SAC chair.

Operate according to the NAS while awaiting NQMC decision

Recommendations for accreditation are considered at the next scheduled meeting of the NQMC. Upon a favourable decision from the NQMC, the secretariat provides a certificate of accreditation to the SAC for provision to the Service, along with an official letter. If the NQMC does not agree to accreditation, the secretariat provides written notification to the SAC for provision to the Service.

Timeframe for provisional accreditation

The provisional accreditation period runs for 24 months from the decision of the NQMC to award accreditation. This period allows a Service to collect significant data to support its application for full accreditation, and ample time to prepare and apply for full accreditation.

Table 5: Key Milestones in Provisional Accreditation for New Services

Getting provisional accreditation		Applying for full accreditation				
1–2 months before commencement	Months 1–15 ie. from 24 to 9 months before NQMC meeting*	Month 16–18 ie. 6–8 months before NQMC meeting	Month 19 ie. 5 months before NQMC meeting	Month 20, or 4 months before NQMC meeting	Month 22 ie. 2 months before NQMC meeting	Month 23 ie. 1 month before NQMC meeting
<ul style="list-style-type: none"> • SCU ensures visit by members of the SAC. • SCU arranges interim data audit. • Service Manager & two SAC members finalise the notification of commencement form. • SAC forwards the form & supporting information to NQMC seeking provisional accreditation. 	<ul style="list-style-type: none"> • Interim data audit to ensure compliance. • Provisional accreditation granted by NQMC. • Service operates according to the NAS. • SCU provides the Service with the application for accreditation form. • The Service undertakes self-assessment. • Service provides 12 months of data to NQMC & report of interim data audit. • The Service consults with SCU and plans accreditation to fit in with quarterly NQMC meetings. 	<ul style="list-style-type: none"> • The Service completes the application for accreditation form & sends to SCU. • SCU liaises with NQMC secretariat to arrange data audit and a site visit. • The NQMC secretariat advises the SCU of the proposed data auditor and site visit team to allow veto rights. • The SCU provides the data auditor with documentation at least 3 weeks before the data audit. • The data audit commences. 	<ul style="list-style-type: none"> • Within 2 weeks of data audit, the auditor forwards a report to the SCU for provision to Service Manager. • SCU/NQMC secretariat finalise site visit arrangements. • The SCU provides documents, including the data audit reports, to the site visit team a minimum of 3 weeks before the site visit. 	<ul style="list-style-type: none"> • Site visit undertaken (if not earlier). • Within 2 weeks of the site visit, the chair of the team forwards a report to the SCU, for provision to the Service Manager. • The Service prepares a response to data audit &/or site visit report, if required. • The SCU provides the SAC with the application for accreditation including site visit & data audit reports & any Service response. • SAC reviews application & provides feedback to Service if required. 	<ul style="list-style-type: none"> • The SCU, SAC (& possibly Service Manager) meet to determine the SAC recommendation to NQMC. 	<ul style="list-style-type: none"> • The SAC forwards all application material & recommendation for decision. • The NQMC secretariat issues a certificate to the SAC for an accredited Service.

* refers to that meeting identified by the Service and SCU as the one timed to best suit the Service's accreditation needs.

5.3 SEEKING ACCREDITATION—STEPS FOR NEW UNITS WITHIN ACCREDITED SERVICES

Introduction

New units, whether relocatable, mobile or fixed, seek the same level of accreditation as applies to the rest of the Service to which they belong. A new unit will not need to undergo the full accreditation process separately. Instead it will become aligned with the accreditation process for the rest of the Service to which it belongs. This is because accreditation covers an entire Service, and is based on Service level, rather than unit level data and performance information.

Having a formal process for establishing a new unit in the context of accreditation provides a pathway for the Service, SCU and SAC to use the tools available through the accreditation process to ensure best possible quality outcomes. Any information collected may be used in support of the Service's accreditation application, which will include the new unit.

Work with the SCU to establish a new unit and notify commencement

Before an existing Service opens a new unit, it must notify the SCU in writing. The letter to the SCU should provide information on:

- the size and type of unit;
- the operational relationship of the unit to the rest of the Service;
- how the unit will be staffed (ie. with existing or new personnel);
- the ability of the unit to meet the NAS to the level of the rest of the Service;
- an exception report on any NAS that may be unable to be met to the level of the rest of the Service (and proposed strategies for managing any associated risks); and
- the Service's recommendation to the SCU on whether it believes a pre-commencement visit and/or an interim site visit is appropriate.

The SCU will forward a copy of the notification of commencement letter to the SAC with any comments it wishes to add.

The Service, the SCU or the SAC may require a pre-commencement visit to take place. This will depend on various issues such as the size and nature of the unit, and any quality issues or possible risks that may have been identified in planning the establishment and implementation of the unit. A pre-commencement visit team consists of a minimum of two members of the SAC (and any other members the Service, SCU or SAC require).

Re-location or refurbishment of existing units is not usually considered to be establishment of new units. However, should the changes be significant, for instance involving a majority of new staff and/or different practices, the SCU may wish to classify the change as establishment of a new unit.

The responsibility for managing quality of service both within usual operations and through changes and expansion rests with the Service Manager and the SCU in the first instance. The SAC should be informed and consulted where appropriate.

Familiarise staff with the NAS, the accreditation process and supporting documents

Staff of all units in a Service should be aware of the principles of accreditation and quality improvement, and have access to the NAS and related documents. Should new staff be employed at a new unit, they must be familiarised with the accreditation process. The Service Manager is responsible for ensuring that general quality improvement processes are in line with NQMC requirements. Self assessment can be used as a tool to assist in establishing new units and in monitoring progress.

Undergo an interim site visit if required

The SAC has primary responsibility for deciding if a site visit of new units is necessary on a case-by-case basis. In some circumstances, the SAC may decide that a pre-commencement visit and careful monitoring of a new unit will suffice. A Service or SCU can also recommend to the SAC that an interim site visit take place. Further information on site visits is in Sections 4.5 and 7.

In deciding upon the most appropriate level of appraisal for a new unit, the SAC considers issues such as:

- the anticipated throughput rate;
- the nature of a new unit (eg. whether or not it is a full assessment and screening unit), and whether or not a new unit is using the same staff, policies and practices as the rest of the Service;
- the level of support available to the new unit at a local and systemic level;
- the current accreditation level of the Service; and
- for Services with two year accreditation with high priority recommendations seeking accreditation of a new unit, action taken to address the high priority recommendations.

Should an interim site visit be required, the SAC/SCU arranges for it to take place within five months of commencement, with assistance from the NQMC secretariat for inclusion of site visitors external to the jurisdiction. Note that this does not preclude the Service or SCU from recommending, or the SAC from instigating, another interim site visit at any time. For instance, if a Service has four year accreditation and a new unit is established close to the beginning of this period, it could be useful to have a second interim site visit as a follow up.

Within two weeks of the interim site visit, the chair of the site visit team forwards the report to the SCU for its information and for provision to the Service Manager and the SAC.

Note that only non-data items will be able to be assessed for new units, as there will not be data available at unit level.

Discuss self-assessment, any site visit report and any issues with the SCU and/or SAC and develop a response if appropriate

If a site visit has been undertaken, the Service Manager, the Program Manager and the SCU may decide to develop a response to the site visit report. This should be provided to the SAC for information.

In the event that a self assessment, site visit or any review against performance standards indicates significant problems with the unit, the SAC advises the NQMC of the following:

- the issue/s and reason;
- the action being taken to address deficiencies;
- the time lines for completion of action; and
- if necessary, any expected delay in its overall Service accreditation recommendation (eg. significant issues related to a new unit could impact on the Service’s readiness for accreditation).

One of the benefits of self-assessment is that it allows Services early notice of problems so that they can work with their SCU and SAC to address these before initiating accreditation proceedings. See Section 11 “Using the risk management approach to improve Service performance” for more information.

Note that most Services will not comply with all of the NAS and this in itself is not necessarily a reason for delaying a recommendation for accreditation. A delay may be considered appropriate by the SAC/SCU where a quality improvement intervention is recommended and a more favourable outcome is expected to result.

Monitor and develop quality in the new unit aiming for Service level standards

The Service Manager is responsible for ensuring the new unit’s performance against the NAS is developed to the level of the rest of the Service.

Engage in the overall Service’s accreditation process

When accreditation becomes due for the rest of the Service, the new unit will be included in this process. A site visit team must visit a new unit. Any interim site visit report on a new unit will form part of the Service’s application for accreditation.

If the unit cannot meet the accreditation level of the rest of the Service, the SCU should consult with the SAC and ensure appropriate quality improvement measures are put in place.

Table 6: Key Milestones For Accreditation of New Units Within Accredited Services

New unit commences		
1 month before commencement	Months 1–3	By month 7
<ul style="list-style-type: none"> • The Service consults with SCU on the SAC jurisdictional annual plan for spacing accreditation and plans to fit in with overall Service accreditation activities. • Service undertakes self-assessment when manager decides most useful. • SCU arranges a pre-commencement visit at its discretion. • Service Manager and SCU member finalise the notification of commencement form and provide to SCU with letter. • SAC sends form to NQMC. 	<ul style="list-style-type: none"> • If interim site visit required, the SCU arranges, with input from NQMC secretariat on appointment of team members*. 	<ul style="list-style-type: none"> • Interim site visit if required. • The Service prepares a response to the interim site visit report, if required*. • The Service implements strategies to address any issues raised in the interim site visit report. • The new unit engages in the Service’s accreditation process. • The SCU provides the SAC with any interim site visit report to form part of the overall Service’s application for accreditation.

*Requirement to be decided by SAC on a case-by-case basis.

5.4 RE-APPLYING FOR ACCREDITATION AT THE END OF AN ACCREDITATION PERIOD

Determine when it is necessary to re-apply for accreditation

Any Service approaching the end of an accreditation period must re-apply for accreditation before the end of its accreditation term.

Services should consult with the SCU and consider the jurisdictional annual plan for spacing accreditation developed by the SAC, as well as the NQMC quarterly meeting dates, in developing a schedule for their accreditation needs. This schedule should address the arrangement and execution of the data audit and site visit.

The SCU will notify accredited Services eight months prior to the end of their term that an application is required.

Start an application for accreditation

The SCU will provide the Service with an application for accreditation form for completion and signature by the Service Manager who will return it to the SCU.

The SCU provides the form to the data manager for completion of the data audit component. After this, the SCU provides the form to the site visit team for their input. The site visit team uses the form as the basis of their report to the NQMC. The completed form remains with the SCU, which provides the Service with a copy of all subsequent components as they are received (eg. any data audit and site visit reports).

At the end of the assessment process, the SCU provides the completed form and copy of the reports to the SAC. The SAC reviews the application and forwards it to the NQMC. This will include all application documentation (application form, any organisation charts, the data audit and site visit reports, and any Service response, any other attachments the Service wishes to include). The SAC provides a covering letter from its chair, giving its recommendation on accreditation for the Service.

Undergo a data audit if required

The SCU will arrange with the NQMC secretariat for a data audit to take place prior to a site visit. Note that a Service with an accreditation level of two years that is applying only for a further two years accreditation is not required to undergo a data audit prior to applying for accreditation unless data issues/processes have been identified as concerning. However, every Service must undergo a data audit each four years. If a data audit is not undertaken, the SAC must provide the NQMC with written assurance that any outstanding issues from the previous data audit have been resolved and that the SAC is satisfied with the Service's data management processes and outcomes. The option to omit a data audit is not available if a Service has undergone significant changes since the previous audit or that audit raised serious concerns.

Undergo a site visit

The SCU will arrange with the NQMC secretariat for a site visit to take place soon after the data audit. The chair of the site visit team forwards the report of the visit to the SCU/SAC within two weeks of the visit, for provision to the Service Manager.

In the event that a self assessment, site visit or any review against performance standards indicates significant problems with the Service, or with any unit or component of the Service, the SAC advises the NQMC of the following:

- the issue/s and reason;
- the action being taken to address deficiencies;
- the time lines for completion of action; and
- if necessary, any expected delay in its accreditation recommendation.

A request for an extension of the accreditation period may be made at this stage, although it is preferable that it is made as early as possible. Requests for extensions to accreditation should include the length of time required, specific reasons for the request and an up-to-date data report for the Service (see Section 5.5).

One of the benefits of self-assessment is that it allows Services early notice of problems so that they can work with their SCU and SAC to address these before initiating accreditation proceedings. See Section 11 “Using the risk management approach to improve Service performance” for more information.

Note that most Services will not comply with all of the NAS and this in itself is not necessarily a reason for delaying a recommendation for accreditation. A delay may be considered appropriate by the SAC/SCU where a quality improvement intervention is recommended and a more favourable outcome is expected to result.

Discuss data audit and site visit reports with the SCU and/or SAC and develop a response if appropriate

The Service Manager, the Program Manager and the SCU may decide to include a response to issues raised in either or both reports. This should be provided to the SAC by the SCU as part of the application package to go to NQMC.

The SCU and SAC meet to determine the SAC recommendation to the NQMC. The Service Manager may be included in this meeting.

The SAC provides application documentation to the NQMC

This includes the completed cover sheets of the application form, any attachments the Service wants to include, plus data audit and site visit reports, and any Service response to these reports, and the SAC recommendation on accreditation included in a covering letter from the SAC chair.

Table 7: Key Milestones in Accreditation of Existing Screening and Assessment Services (Re-Applying)

8 months before end of accreditation	6 months before end of accreditation	5 months prior to NQMC meeting	4 months prior to NQMC meeting	2 months prior to NQMC meeting	1 month prior to NQMC meeting	NQMC meeting
<ul style="list-style-type: none"> The SAC informs the Service of the need for an accreditation review before the end of the current accreditation term. The Service consults with the SCU to consider the SAC jurisdictional annual plan for spacing accreditation. Note: NQMC meetings are held quarterly in February, May, August & November each year. Service undertakes self-assessment when manager decides most useful. The SCU provides the Service with the application for accreditation form. A new application is to be made each time a Service is accredited. The Service completes the application for accreditation form & sends with available documentation to the SAC via the SCU. 	<ul style="list-style-type: none"> The SCU liaises with the NQMC secretariat for appointment of a data auditor (where required) & site visit team. The NQMC secretariat advises the SCU of the proposed data auditor & site visit team to allow veto rights. The SCU reviews the Service's accreditation applications to ensure all requirements are met prior to a site visit. SAC advise NQMC of any changed timelines & action to resolve. The SCU provides the data auditor with documentation at least 3 weeks before the data audit. 	<ul style="list-style-type: none"> The data audit commences. Within 2 weeks of data audit, the auditor forwards a report to the SCU for provision to Service Manager. 	<ul style="list-style-type: none"> The SCU provides documents, including the data audit report, to the site visit team a minimum of 3 weeks before the site visit. Site visit undertaken. Within 2 weeks of the site visit, the chair of the team forwards a report to the SCU, for provision to the Service Manager. The Service prepares a response to data audit &/or site visit report, if required. 	<ul style="list-style-type: none"> The SCU provides the SAC with the site visit & data audit reports & other documentation. The SAC reviews application and provides feedback if required. The SCU, SAC (& possibly Service Manager) meet to determine the SAC recommendation to NQMC. 	<ul style="list-style-type: none"> The SAC forwards to the NQMC a full application package & recommendation for accreditation. 	<ul style="list-style-type: none"> The NQMC makes a decision on accreditation. The NQMC secretariat issues a certificate to the SAC for an accredited Service.

Process finalised before the end of accreditation period

5.5 EXTENSIONS TO ACCREDITATION PERIODS

It is the Service's responsibility to ensure accreditation is reviewed at the appropriate date. Extensions of accreditation (eg. until the next NQMC meeting) will only be granted under exceptional circumstances. The review date for accreditation decisions is the date of the NQMC meeting when the accreditation decision is made (in the appropriate forward year). Meetings of the NQMC are usually held quarterly in February, May, August and November.

An extension of accreditation is to be sought at least six months prior to an accreditation decision falling due. A Service should develop a request in conjunction with its SCU and SAC.

A Service is allowed only one extension of accreditation. The NQMC will grant extensions of no longer than six to nine months. Extensions will not be granted to Services with two year accreditation with high priority recommendations, or to those with provisional accreditation. Where the accreditation of a Service has been allowed to lapse, the NQMC will not consider extensions (see 5.7).

As extenuating circumstances will always be considered by the NQMC, the committee retains the ability to increase the time period of extensions or to grant second extensions on a case-by-case basis. Extenuating circumstances include situations that are unavoidable and over which the Service has little or no control, or where no reasonable solution other than an extension to accreditation could be applied.

Requests for extensions should specify the amount of time required and reasons and be accompanied by data from the most recent 12 month period and a jurisdictional annual plan for spacing accreditation against which the request may be examined. A Service applying for an extension should provide information about activities it has or proposes to put in place to address the issues that have led to its inability to meet the accreditation timeframe.

5.6 CALCULATION OF THE ACCREDITATION PERIOD

For accredited Services

A new period of accreditation is calculated to commence from the time accreditation would have expired, including extensions to the accreditation period. For example, if a Service was initially accredited until 30 August 2005, received an extension until 30 November 2005 and held its site visit on 30 July 2005, the period of accreditation would be granted from 30 November 2005.

This example shows the SCU has factored in a meeting of NQMC in November to consider the Service's accreditation application, and has ensured that the Service does not run out of accreditation before a meeting.

For new Services or units

New accreditation periods start from the date of the NQMC meeting at which the decision to accredit the Service (or unit) was made. For instance, if a new Service applied for accreditation

in July 2005 and the NQMC considered its application and agreed upon its accreditation level at a meeting in February 2006, then that Service’s accreditation would commence from the date of that meeting in February 2006.

The accreditation period for new units will match that of the rest of the Service. Therefore, if a Service has four-year accreditation and a new unit is added at the end of the third year of that accreditation period, the new unit’s accreditation will expire at the end of the fourth year.

End of the accreditation period

The accreditation period will end on the last day of the respective month to ensure that even if the NQMC meeting occurs at the end of the month the service will be accredited until this time.

5.7 LAPSED ACCREDITATION

A Service’s accreditation is considered to have lapsed if it does not:

- re-apply for accreditation before the end of its current accreditation period, and proceed to secure another period of accreditation; or
- seek an extension to its accreditation period.

A Service in either of the above situations is technically non-accredited. Therefore, to become accredited it will need to apply for provisional accreditation as if it were a new Service. See Section 3.5 “Implications for Services of non-accreditation”.

Where the accreditation of a Service has been allowed to lapse, the NQMC will not consider extensions. It is the responsibility of the SCU to arrange the site visit well before the time of a Service’s accreditation expiring. This allows for issues of concern to be addressed, and averts the risk of a Service becoming non-accredited through allowing accreditation to lapse.

5.8 ACCREDITATION AND SIGNIFICANT CHANGES TO A SERVICE

A Service may achieve accreditation and then undergo significant changes, for instance, in:

- funding arrangements;
- provider/s;
- senior or key staff;
- structure (ie. amalgamation of two Services, realignment of a Service within organisation);
- physical amenities and/or location; and
- combinations of the above or other.

Such changes have the capacity to impact on service provision, and therefore need to be monitored. In the first instance, it is the responsibility of the Service Manager and the SCU to ensure that quality of service is maintained throughout periods of change.

The Service needs to inform the SAC of all changes above as, or preferably before, they occur.

The SAC should notify the NQMC in writing of significant changes as they occur, and provide available data, including an annual data report. Services with significant changes will be considered by the NQMC on a case-by-case basis to determine what, if any, additional monitoring and reporting is needed.

The SAC will review data and monitor the Service's performance and notify the NQMC of the significant changes and any recommendations made to the Service on performance.

6

THE DATA AUDIT

This section describes the elements of a data audit and the roles of the data auditor and Service activities in implementing an audit. The purpose and objectives of a data audit are outlined in Section 4.4.

6.1 THE ROLE OF THE DATA AUDITOR

It is the role of the data auditor to:

- ensure that the Service has a complete and current data management manual based on the NAS, the National Data Dictionary and the Data Audit Checklist;
- ensure that there are appropriate data flows and that the processes and procedures observed during the data audit are congruent with the policy and procedures manual;
- ensure as comprehensively as possible that the data reported against the NAS are timely and accurate;
- ensure that there is a supportive environment for the policies, processes and procedures that relate to data management;
- gauge the level of understanding by staff of the relevant policies, processes and procedures that relate to data management; and
- be totally independent of the Service applying for accreditation.

The data auditor should **not** be concerned with:

- whether the procedures and processes are the same as in the data auditor's own Service;
- whether the structure of the Service is the same as the data auditor's own Service;
- whether or not the Service is meeting the NAS; and
- providing any form of education to Service staff.

It is important that the data auditor focus strictly on the performance and operation of the Service in relation to the data audit checklist and the relevant NAS, and not in relation to any other Service.

Should the data auditor believe that Service staff would benefit from education on data management issues, this can be stated in the data audit report.

6.2 PRE-AUDIT ACTIVITIES

Appointment of the data auditor—the SCU and NQMC secretariat

Data audits are undertaken by a trained data auditor from a different jurisdiction to that being audited. The NQMC secretariat will appoint a data auditor at the request of the SCU.

The SCU has the right to veto the first data auditor appointed.

The costs of the data audit are met by the jurisdiction being audited and the SCU is responsible for advising the data auditor of arrangements prior to the audit.

The Service

At least three weeks prior to the data audit, the Service provides the data auditor with the following information:

- contact details of the Service Manager ;
- contact details of the Service data manager;
- copies of all data management procedures, flowcharts and data collection forms or any other documentation that relate to the data management process;
- information on the structure and size of the Service applying for accreditation, including the number of screening units, fixed and mobile, and an indicator of screening and assessment activity levels;
- a list of Service staff and positions; and
- a copy of the previous data audit report outlining any issues or review points identified.

The data auditor

The data auditor provides the Service with the following documents prior to the on-site audit:

- data audit plan developed by the data auditor and sent to the Service at least one week prior to the audit. This plan provides a schedule of the activities that need to occur during the data audit to enable a planned progression of the data audit;
- data audit checklist to provide the Service with information relating to the areas of data management that the data auditor will be investigating; and
- a copy of the data audit guidelines if the Service does not possess a copy.

The data auditor contacts the Service Manager and/or the data manager before the data audit to introduce themselves, and to discuss any areas of the data audit that may be unclear and to confirm details of the visit. Before visiting the Service, the data auditor checks all documentation received from the Service against the data audit checklist and ensures that the Service is collecting all the required data.

6.3 THE ON-SITE AUDIT

The data audit will usually be conducted over two days and during this time the data auditor will:

- assess the documented and observed data management procedures and processes throughout the data flow against the data audit checklist through interview and observation of all staff involved in data collection or processing;
- request and view client records to ensure the adequacy of file management and security, file tracking, file condition and completeness, data accuracy and the management of errors or problems;
- conduct specific checks on the data to ensure that reports are relevant and accurate;
- assess the NAS that relate to data management; and
- meet with the data manager and Service Manager to discuss the findings of the audit and agree to areas requiring resolution.

A data audit is mandatory before every accreditation site visit, whether two or four yearly.

6.4 AN INTERIM DATA AUDIT

This is a scaled-down version of a full data audit and may be used in the following situations:

- to assess the capacity of a new Service to collect data according to BreastScreen Australia requirements and to ensure that required data management processes are in place;
- as part of follow-up action, for example, if a Service was not meeting some NAS in the period between accreditation reviews. The SAC and/or SCU can recommend an interim data audit as part of a management plan submitted to NQMC in the case of a poorly performing Service; and
- any other time the SAC or the NQMC believe it is appropriate.

The use of an interim data audit is at the discretion of the SAC in the first instance, and then the NQMC, whose decisions will be based on criteria such as, in the case of a new Service or unit coming on line, the anticipated throughput. In the case of under-performing Services or those with high priority recommendations, both the SAC and the NQMC will consider the number and category of standards not being met, and the related risks.

A Service seeking provisional accreditation should provide its interim data report to the SAC as an attachment to its application for accreditation. There is no separate form for an interim data audit report. The Data Audit Report form should be used for this purpose. While a new Service will not be able to meet all the requirements until it has commenced collecting data, this can be explained on the data audit checklist part of the form, which has a section for items unable to be assessed.

6.5 AFTER THE ON-SITE DATA AUDIT

The data auditor will:

- complete the data audit report within two weeks of the visit and forward it to the SCU;
- consult with the SCU on any issues or review points identified, including developing a timeframe for resolution;
- at the end of the agreed timeframe, consult with the SCU (and Service if required) to verify that any issues or review points identified during the data audit have been resolved to the satisfaction of the data auditor; and
- formally close off the data audit by writing to the SCU to either acknowledge resolution of issues raised in the data audit, or to refer unaddressed issues back to the SAC for management.

The SCU forwards the data audit report to the Service Manager and the SAC. The SAC provides the data audit report to the NQMC secretariat together with the site visit report, application forms, supporting material and any response from the Service for consideration by the NQMC at its next scheduled meeting.

6.6 CONFIDENTIALITY AND CONFLICT OF INTEREST PROVISIONS FOR DATA AUDITORS

Data auditors will maintain strict confidentiality concerning the auditing of a Service. Information gathered during the data audit must not be discussed outside the Service, apart from with the SCU as required. All copies of the documentation that do not form part of the data report to the NQMC will be either destroyed or returned to the Service on completion of the audit. All data auditors must complete the deed poll—confidentiality and conflict of interest undertaking prior to commencing in the role. Forms will be provided by the NQMC secretariat, which will collect and maintain signed copies.

6.7 DATA AUDIT REQUIREMENTS FOR CENTRAL DATA REPOSITORIES AND/OR FOR SCUs

To ensure that standards are maintained for the collection and management of data within the BreastScreen Australia Program, it is recommended that the central data management area at jurisdictional level undergo a data audit at a minimum of four yearly intervals, unless performance issues have been identified.

Some jurisdictions have a data registry that may sit within the SCU, while others have the registry further removed from the SCU. Regardless of the local arrangements, the SCU in each jurisdiction should ensure that all of the data management functions that occur at a jurisdictional level, including central data collection, storage arrangements and data analysis and reporting are subject to a data audit. This can be done either as part of the regular Service accreditation process should it fit within this scope, or separately. For instance, where the SCU is separate from the Services (ie. as is currently the case in Queensland, New South Wales and Victoria) it could be arranged that an audit is undertaken on a four yearly cycle.

As part of their role in assessing a Service, the site visit team and the data auditor can make recommendations regarding the policy and practice of an SCU in relation to the qualitative and quantitative NAS. This is not a formal audit process, but rather a means of highlighting both good practice and opportunities for an SCU to better support Services to meet the standards.



THE SITE VISIT

This section describes the site visit and the roles of the site visit team and the Service in implementing a visit. The purpose of a site visit is explained in Section 4.5. The selection of site visit teams, the training of site visitors and overall administration is managed by the NQMC secretariat, on behalf of the NQMC. All site visitors appointed to a site visit team will have undertaken relevant training. These points are covered in more detail in Section 12.

7.1 THE ROLE OF THE SITE VISIT TEAM

The site visit team will:

- assess the effectiveness and quality of service provision of the Service and all its components against the NAS;
- verify that the information provided in the application forms for this purpose, including any self-assessment of the Service, is accurate;
- examine the quality management systems and procedures that are in place;
- identify any changes in procedures required to ensure improved quality management;
- provide a report to the Service, the SCU, the SAC and the NQMC identifying areas which may warrant further attention, including those requiring immediate action and less urgent improvements;
- identify those areas that are assessed as meeting NAS; and
- provide information to assist the SAC in forming a recommendation on whether, and at what level, the Service should be accredited.

The site visit team should **not** be concerned about:

- whether the procedures and processes are the same as in another Service;
- whether the structure of the Service is the same as another Service; or
- providing any form of education to Service staff.

It is important that the site visit team focus strictly on the performance and operation of the Service in relation to the NAS, and not in relation to any other Service.

7.2 PRE-SITE VISIT ACTIVITIES

The SCU and NQMC secretariat

Appointment of a site visit team

The NQMC secretariat appoints site visit teams from those included on the register, upon request from the SCU. The secretariat will notify the SCU of the nominated site visitors as soon as possible to allow the Service to use its veto rights and to allow the SCU to then arrange and schedule the visit. The secretariat will provide a list of potential site visitors that is larger than the required number in the team to allow for possible vetos.

The SCU, in consultation with the Service, has the right to veto up to three members of the proposed site visit team. When vetoing proposed site visitors, the SCU should provide broad reasons, such as a perceived conflict of interest through being a previous employee or having undertaken a prior site visit for that Service. This information will be used to increase the efficiency of the appointment process for site visit teams.

In drawing together a team, the secretariat balances the needs of individual Services with the skills and experience of those available on the register. The secretariat will be confident that it has formed the best possible team for each visit from those available.

The site visit team will consist of approximately five members depending on the size and requirements of the Service seeking accreditation. The team will comprise a range of experts and must include a radiologist, radiographer and a Program Manager or Service Manager. Other members of the team will be selected depending on the requirements of or difficulties being experienced by the Service. These could include a surgeon, medical director, pathologist, nurse/counsellor, expert in quality management and consumer representative.

No more than one member of the team will be assessing for the first time. No member of the team should be drawn from the Service being assessed or the Service's jurisdiction.

Prior to the site visit, the NQMC secretariat will formally nominate one member of the team to act as the chair. The nominee has the right to decline the role. To ensure the workload and responsibilities of site visits do not fall largely upon the appointed chair, all site visit team members will contribute fully to all aspects of the site visit and to preparation of the subsequent report. The role of chair is highly important and selection can be considered an honour and recognition of skills. It is expected that all site visitors will have the opportunity to chair a site visit over time.

The SCU

Provide material to the site visit team members

The SCU provides each member of the site visit team with copies of the following, no less than three weeks prior to the site visit:

- completed Application for Accreditation form from the Service;
- summary of Service's performance against the collated risk levels per cluster;
- supporting documentation such as manuals, structure charts;
- data audit reports;
- previous site visit report;
- other relevant documentation including trend data;
- a list of all staff, their position and qualifications, indicating their availability during the site visit; and
- a letter explaining the procedures for payment of travel and accommodation allowances and honorariums as applicable to individual site visitors.

This will allow team members sufficient time to examine the forms and supporting material and to decide on aspects of the Service needing further information or follow-up.

Work with the Service to develop a program for the site visit

The SCU works with the Service Manager, in consultation with the State or Territory Program Manager to develop a flexible program for the site visit. This is important to ensure availability of appropriate staff at agreed times, and that optimum use is made of limited time.

Essential elements of the site visit program include:

- a meeting of the site visit team to plan their activities for the visit;
- a meeting with Service staff for introductions to be made;
- time for clinicians to meet with clinical specialists; and
- time for the site visit team to meet for confidential discussions and work on the site visit report towards the end of the visit and before verbal feedback is provided to Service staff.

The remainder of the schedule is planned by the Service with the SCU. The site visit team can change the schedule in consultation with the Service to ensure the aims of the site visit are best met.

The Service

Work with the SCU to develop a program for the site visit (see above)

Decide upon the best way to operate the Service during the visit

It is probably best to not operate at full capacity (particularly in the case of a combined screening and assessment clinic) on the day a site visit is scheduled.

If possible, the Service should scale down screening and assessment operations for the day, to allow the site visit team to see the unit in operation, and to speak with key staff with minimal disruption to service provision and clients.

Another option is to roster backup for designated positions for the day to free up staff time during clinics, allowing interaction with the site visitors.

Organise accommodation and support for the site visit team

Site visitors should have access to:

- a room for their exclusive use during the site visit;
- where possible, a laptop or other computer with the relevant electronic templates loaded, and a printer;
- a telephone and facsimile machine; and
- refreshments.

Secretarial support may be provided to assist the site visit team. Care should be taken to ensure confidentiality provisions are met.

The site visit team

The site visit team may meet or teleconference before a site visit to discuss any issues and receive a briefing from the SCU. If a teleconference is the preferred option, it is arranged by the SCU to take place once all documentation has been received by the team in the week before the visit. Another option recommended by the NQMC is for the site visit team to arrive at the site visit locality in time to have a preliminary meeting.

7.3 DURATION OF SITE VISITS

The duration of site visits will depend on size of the Service, the number of units it contains and its geographic area. As a guide, site visits can take from two to three days, and one to three separate sites are all that can reasonably be visited in one day. Services with a larger number of units may require the site visit team to stay more than one night in the area. An interim site visit may take less than a full day.

7.4 SCOPE OF THE SITE VISIT

Each component of the Service should be visited, whether mobiles, relocatables or fixed venues. There is a long lead up time in the accreditation process to allow Services to schedule operations in such a way that all components can be made accessible to the site visit team over the period of the visit.

An exception to this would be where a mobile unit cannot be located within reasonable travelling distance. In this circumstance, details of the layout of the van should be made available to the site visit team. Relevant documentation should be made available, and any other informing material, such as photographs or video recordings, and copies of films for quality assurance checks by the radiologist on the site visit team. If possible, staff from the mobile unit should be available to meet the site visit team or at least to talk to them by teleconference. Arrangements such as organising staff rotation to allow for one or more members to be available to meet with the site visit team should be considered.

An option that can be used at the discretion of the SAC in exceptional circumstances is to arrange for an interim site visit (see Section 4.5) to assess some components of the Service in the 12 months prior to the full site visit. Information from any interim site visit can then be included in the accreditation process.

The SCU must ensure that every unit in a Service undergoes a site visit, whether full or interim, within each accreditation period.

A full site visit can be instigated by NQMC, the SAC/SCU or the Service at any time. This is to ensure that should any significant concerns exist, sufficient information is available to support quality improvement strategies and accreditation decisions.

The site visit team must visit any unit that has not had an interim site visit within the 12 months prior to the end of the Service's accreditation period.

It is important that the site visit focus strictly and objectively on the performance and operation of the Service in relation to the NAS, and not in relation to any other Service. The site visit team will not consider aspects of the Service outside the scope of the NAS.

The site visit team can make recommendations regarding the policy and practice of an SCU in relation to the qualitative and quantitative NAS. This is not a formal audit of the SCU, but rather a means of highlighting both good practice and opportunities for an SCU to better support Services to meet the NAS.

7.5 DURING THE SITE VISIT

The SCU and Service Manager will determine how to best brief and introduce the site visit team. For instance, the Service Manager may provide an initial briefing to Service staff and the site visit team. The chair of the site visit team could then introduce the team and address staff informing them of the days' proceedings. In addition, the SCU may want to provide a briefing giving the overall jurisdictional context. Some aspects of the briefings may be confidential to the site visit team, and it is the responsibility of the SCU to manage this.

The Service Manager and other relevant staff will meet with the site visit team at the commencement of the site visit to give the team an overview of the Service, its background and structure, staffing, session times and review meetings. The Service may then wish to discuss its self-assessment against the NAS and decision making tool, and its quality improvement plan. It may also respond to issues raised in the previous site visit or data audit reports.

The site visit team should have access to all relevant Service documentation for assessment purposes. This includes films and performance data from each unit, especially trend data where the NAS are not met, policies and procedures manuals as per the NAS, training records etc. Information gained during the site visit will enable the SAC to make a fully informed recommendation to the NQMC concerning the accreditation of the Service.

The site visitors may also request a random selection of screening and assessment client files be made available to them for audit purposes during the visit.

During the visit, the chair will encourage all team members to contribute to every aspect of the site visit, and facilitate the site visit team to reach a consensus in summing up the site visit. The chair will also coordinate the report writing relating to the findings at the site visit in consultation with the other site visit team members.

While there is no specific requirement for client consultation during a site visit, as the main purpose of the visit is to review the processes and activities of the Services in relation to the NAS, client consultation may be undertaken. The site visit team will need to attain informed consent and to consider a range of issues such as privacy and appropriateness. For instance, it is not appropriate to approach women who are attending for a screening or assessment appointment while it may be appropriate to speak to consumers outside of clinic times or to consumer volunteers.

The NAS include the requirement to “ensure that Services are acceptable and appropriate to the needs of the eligible population.” Services are required to collect information to illustrate their progress against this requirement and site visitors should assess this information. In addition, all members of a site visit team, including any consumer representative, are encouraged to consider the consumers' perspective when undertaking a site visit.

It is vital that plenty of time is allowed for the site visit team to meet at the beginning and end of the visit to come to a decision and to complete the site visit report form. Where possible it is advantageous to have the report finalised for signature by all members of the site visit team at the completion of the visit, although this may not be possible (see Section 7.7).

At the close of the visit, the team will meet with the key Service staff to provide verbal feedback, discuss their assessment generally, and allow opportunity for comment and for professional exchange.

At the end of a visit the chair may also choose to address all staff, thanking them for their cooperation and assistance during the visit.

7.6 CONFIDENTIALITY AND CONFLICT OF INTEREST PROVISIONS FOR SITE VISITORS

Site visitors must maintain strict confidentiality concerning the accreditation of the Service. Accreditation documentation should be treated with confidentiality at all stages of the process. For instance, documents should be marked “Confidential” and transported securely.

Information gathered during the site visit should not be discussed outside the site visit team, apart from reasons relating directly to accreditation. For instance, the SCU or SAC could contact the chair of the site visit team to seek clarification of a matter in the site visit team’s report.

Site visitors should keep copies of their notes for six months after a site visit in case of an appeal. After that, all documentation created as part of the site visit process, including notes of the site visit team, should be destroyed. Documentation provided by the Service, such as manuals, structure charts, and reports, should be returned to the Service at the end of the site visit. Documents should be destroyed if they contain annotations made by the site visit team that could be considered sensitive. Alternatively, such annotations may be removed or obscured before return of the documents to the Service. The chair of the site visit team may take a copy of the Service’s application for accreditation (which includes the NAS non data report) and the annual data report where relevant, should these be needed to finalise the site visit report. Once this has been done, the chair should return the documents to the Service or destroy them. The Service, SCU and/or SAC may keep copies of documentation for their records.

All site visitors are required to complete the deed poll—confidentiality and conflict of interest undertaking upon appointment to the site visitor register. If for any reason the form is not completed at this stage, a site visitor must ensure they have completed a form prior to commencing a site visit. Forms are available from the SCU and/or the NQMC secretariat. The secretariat will collect all signed forms. The SCU and/or Service may retain or request copies of the signed form as required.

7.7 FOLLOWING THE SITE VISIT

The site visit team—provision of feedback to the Service

The site visit team meets with Service staff for a debriefing of the site visit and to thank staff for their support. The site visit team cannot discuss accreditation levels or give any recommendation as to the Service’s likely accreditation outcome. It can provide an overall

impression of the Service’s performance gained during the site visit, and discuss the process and any highlights and issues. Various team members may wish to comment on findings that are relevant to their area/s of expertise. The debrief should ensure that the Service staff have a realistic understanding of the site visit team’s findings and therefore will not be surprised upon receiving the written report.

The site visit team—finalisation of the report

Each member of the team should sight the final site visit report and have time to consider it before they sign the document. Ideally this would be done at the close of the site visit. However, given that extra time may be required to finalise the report, it is appropriate for the document to be distributed via E-mail, post or facsimile to members of the site visit team for signature, with regard to confidentiality requirements.

The chair of the site visit team forwards the report of the visit to the SCU within two weeks of the visit, for provision to the Service Manager and the SAC. Note that if the document was distributed separately to members as outlined above, it is acceptable for the chair to provide individually signed copies to the SCU.

The SCU

If not already finalised, the SCU arranges payment of allowances and honorariums for eligible site visitors and data auditors. It also reviews all applications, site visit reports and data audit reports and ensures all necessary documentation is forwarded to the SAC within four weeks of the site visit being finalised.

The SCU arranges a meeting of the SAC to consider the full application. The Service Manager may be invited to attend.

Meeting of the SAC, SCU (and possibly Service Manager)

After the site visit, the SCU coordinates a meeting between these stakeholders to assist the SAC in determining its accreditation recommendation to the NQMC.

The SAC assesses all accreditation documentation, ensuring it is in line with the NQMC requirements and is fully completed. It also determines a recommendation regarding the Service’s application for accreditation.

The SAC forwards the originals of the following documents to the NQMC secretariat in time for distribution to NQMC members for the next meeting:

- a covering letter signed by the chair of the SAC, including recommendation for accreditation, any report the SAC wishes to make, and an outline of any follow up action required;
- summary of Service’s performance against the collated risk levels per cluster;
- data audit report;
- site visit report; and
- any other supporting documentation it believes appropriate.

The documents are sent in a confidential manner (such as by courier and marked 'Confidential'). The SAC provides a copy of its recommendation, report and covering letter to the SCU for information.

To protect confidentiality, working copies of applications and related material are destroyed after this meeting. The SAC may retain copies for its records.

8

NQMC CONSIDERATION OF THE ACCREDITATION APPLICATION

The NQMC considers a Service's application for accreditation in the context of all supporting material provided, including the data audit and site visit reports and the recommendation of the SAC.

The NQMC decides whether or not a Service should be accredited and the level of accreditation to be granted to the Service. If the NQMC is satisfied that the requirements have been met, accreditation will be granted at the requested level.

Members of the NQMC who are associated with the Service (or jurisdiction) being discussed, or who work in the SAC or SCU for that State or Territory, should be excluded from the decision making and voting process. This does not restrict such members from contributing to the discussion before the decision making process. In addition, any member of the NQMC who undertook a role as site visitor or data auditor for a Service being considered for accreditation is not to contribute to discussion in relation to their experience in this role. It is the responsibility of the chair of the NQMC to support objective decision making by implementing these requirements.

For the purposes of record keeping, the NQMC secretariat compiles a statement of reasons for each decision made. This includes the relevant finding of fact, the evidence on which those findings were based and the reasons for the decision.



AFTER AN ACCREDITATION DECISION IS MADE BY NQMC

To ensure confidentiality, NQMC members return all copies of the application documents to the NQMC secretariat to be destroyed after an accreditation decision is reached.

The secretariat will keep one copy on file as a record. The Australian Government Department of Health and Ageing is also provided with a copy by the secretariat for its records.

After each NQMC meeting the NQMC secretariat also updates the accreditation status table, which is a national list of accredited Services. This is circulated annually to each State and Territory program and to NQMC members.

Once accreditation has been approved, the NQMC secretariat advises the SAC in writing of the NQMC's decision. The SAC then advises the Service of the NQMC's decision. This may be by forwarding a copy of the NQMC letter to the Service.

The NQMC secretariat provides a Certificate of Accreditation to the SAC for provision to the Service.

10

APPEALS OF DECISIONS

10.1 RIGHT OF APPEAL

Any BreastScreen Australia Service has the right to appeal a decision made by the NQMC in relation to their accreditation status. The appeal may either be against the decision of the NQMC not to accredit the Service or against the term of accreditation granted by the NQMC.

The appeal should be made in writing through the SAC to the chair of the NQMC within four weeks of the Service being notified of the decision (ie. within four weeks of formal notification by letter from the NQMC, not four weeks from the time of the NQMC meeting date). The application for a review of accreditation decision should include a statement of the grounds on which accreditation reconsideration is sought. The form “Appeal Application” is to be used when lodging an appeal.

The chair of the NQMC will formally acknowledge receipt of the appeal in writing.

The most recent accreditation decision will remain in force until the appeal is finalised.

10.2 GROUNDS FOR APPEAL

An appeal may be made on one or more of the following grounds:

- relevant and significant evidence was not properly considered or was incorrectly interpreted;
- the reasons provided for the accreditation decision are inconsistent with the evidence upon which that decision was made;
- an error was perceived to be made in the accreditation decision or the process leading to that decision; and
- other.

10.3 NQMC CONSIDERATION OF APPEAL

In the first instance, the NQMC will consider the appeal, reviewing its original decision and recommendations.

To inform its consideration (and possible review of its earlier decision), the NQMC may inspect the premises of the Service, invite any relevant person to appear before the Committee, or seek additional information from the Service, SCU or SAC.

Should the NQMC decide (by consensus) to change its earlier accreditation decision, it will notify the Service in writing (via the SAC with a copy to the SCU).

If the NQMC decides (by consensus) to retain its original accreditation decision, the Service will be notified in writing (via the SAC with a copy to the SCU) that an Appeals Committee will be appointed.

The NQMC will ensure the Committee's decision is recorded in writing and maintained by the secretariat. During the reconsideration, and any subsequent appeal process, the SAC liaises with the NQMC and works with the SCU to support the Service.

10.4 FORMATION AND OPERATION OF AN APPEALS COMMITTEE

If required, the NQMC will instruct its secretariat to convene an appeals committee and refer the matter to that committee. The role of an appeals committee is to independently examine issues of probity rather than to deal with Program content. The NQMC secretariat will provide administrative support to the appeals committee.

The appeals committee will comprise:

- the chair or delegated member of the Australian Screening Advisory Committee. (Note that in the case of a conflict of interest, this role is to be undertaken by a suitably qualified, independent person to be determined by the secretariat in consultation with the Australia Government Department of Health and Ageing);
- a BSA Program representative (such as a Service Manager);
- a consumer representative, who may be a member of the NQMC;
- an Australian Government representative (not a member of the NQMC); and
- a representative of the legal profession who is not an NQMC member (whose role is to ensure fair and lawful proceedings, not to represent either party).

The chair shall be either the chair of the Australian Screening Advisory Committee or the Australian Government representative.

No person with a conflict of interest (for instance, a current or past employee of the appealing Service) is to take part in an appeals committee. All members of an appeals committee will be required by the secretariat to sign a deed poll—confidentiality and conflict of interest undertaking prior to the committee convening. The secretariat will keep the original signed forms as a record.

Before the committee is convened, the secretariat will ensure members have access to all relevant BreastScreen Australia documents (eg. the NAS, the Decision Tool, the accreditation handbook etc). Members will also be provided with copies of the Service’s application, including all supporting documents such as the site visit and data audit reports, the SAC report and recommendation, the NQMC original decision).

All members of the appeals committee, including the chair, are entitled to vote. The appeals committee’s recommendations shall be carried on the basis of a majority vote. If the appeals committee is unable to reach a majority vote, the chair will exercise the deciding vote. The secretariat has no voting rights.

Reimbursement of costs to eligible members of an appeals committee will be the responsibility of the jurisdictional SCU. Section 12, “Payment and reimbursement guidelines for site visitors and data auditors” provides an indication of costs.

10.5 CONSIDERATION OF APPEALS

The appeals committee will:

- review all information it considers relevant to the appeal;
- request any additional information required;
- inspect the premises of the Service if required; and
- invite any relevant person to appear before the committee.

10.6 RECOMMENDATIONS OF AN APPEALS COMMITTEE

An appeals committee may, on considering all submissions and other relevant evidence, recommend to the NQMC one or more of the following:

- confirmation of the original accreditation decision;
- variation of the original accreditation decision, in whole or part, including varying the original term of accreditation; and/or
- re-survey of the relevant premises, in whole or in part, including a new site visit.

The appeals committee must record all its discussions and deliberations. The appeals committee must submit its recommendations to the NQMC along with all minutes and a summary of its deliberations, including any significant information that influenced its decision making process or recommendation.

The secretariat will advise the appellant in writing of the appeal outcomes.

10.7 TIMING

The review decision by the NQMC or the appeals committee should be finalised within three months of the application for review of accreditation decision by the SAC.

10.8 CONFIDENTIALITY AND CONFLICT OF INTEREST PROVISIONS FOR NQMC AND APPEALS COMMITTEE MEMBERS

Members of the NQMC and any appeals committee convened must maintain strict confidentiality concerning the accreditation of a BreastScreen Service and any related appeal. All accreditation and appeals documentation should be treated with confidentiality at all stages of the process. For instance, documents should be marked “Confidential” and transported securely.

Information provided for the purposes of accreditation or appeals decisions should not be discussed outside the relevant committee meetings, except as required through the role of the committee in gathering further information, say through discussions with SACs.

All copies of accreditation or appeal related documentation that do not form part of a final report to the NQMC will be either destroyed or returned to the Service on completion of the process. Documents should be destroyed if they contain annotations made by the committee members that could be considered sensitive. All other documentation created as part of the process, such as notes of committee members, should be destroyed once the business of the committee is finalised.

All NQMC and appeals committee members are required to complete the deed poll—confidentiality and conflict of interest upon appointment to a committee. If for any reason the forms are not completed at this stage, a committee member must ensure they have completed a form prior to commencing consideration of an accreditation application or an appeal. Forms are available from the SCU in the first instance, and the NQMC secretariat. The secretariat will collect and maintain all signed forms.

10.9 ADMINISTRATION OF APPEALS COMMITTEES

To support the appeals process the secretariat will:

- establish a register of people eligible to take part on appeals committees. This can be an adjunct to the national site visitor and data auditor register;
- ensure that those on the appeals committee register receive training and information on the BreastScreen Australia Program as required;
- provide members of an appeals committee with confidentiality and declaration of interest forms prior to commencement of an appeal;
- maintain original signed copies of these forms for records;
- provide secretariat support to the committee and keep records of decisions for file, and provide a record to the Australian Government Department of Health and Ageing; and
- advise the appellant in writing of the appeal outcomes.

11

USING THE RISK MANAGEMENT APPROACH TO IMPROVE SERVICE PERFORMANCE

Using a risk management approach requires, as well as the categorisation of a risk, the development and implementation of a strategy for managing that risk. The management of Service performance resides with the BreastScreen State and Territory Program Managers.

The main role of the NQMC is to make decisions on the accreditation status of Services and to monitor performance of Services against the NAS in the period between accreditation reviews, that is, on an annual basis through the data reports. This ongoing monitoring is important for the NQMC to gain a national perspective on the overall performance of BreastScreen Australia, to review the adequacy of the NAS themselves and to provide advice to the NAC on activities to support quality improvement in BreastScreen Australia.

Table 8 sets out management guidelines for each risk level and outlines the roles and responsibility of the stakeholders involved in BreastScreen Australia for dealing with gaps in performance.

As outlined in Section 5, if the site visit, the data audit report or any review against performance standards indicate that the Service does not comply with the Level 1 NAS, the SAC should advise the NQMC of the following:

- the issue/s and reason;
- the action being taken to address deficiencies;
- the time lines for completion of action; and
- if necessary, any expected delay in its accreditation recommendation.

The SAC will monitor progress, and once satisfied that the Service has put in place appropriate quality improvement and corrective measures, the SAC will forward a final written recommendation on accreditation to the NQMC. If satisfaction is not achieved, the SAC will inform the NQMC of the situation and a recommended course of action. The SAC may also need to request an extension of the accreditation period from the NQMC, and this should be done as early as possible to avoid accreditation lapsing.

Table 8: BreastScreen Australia NAS risk management policy

Risk categorisation	BreastScreen Australia management category	BreastScreen Australia NAS risk management policy
Severe or High risk	Level 1	<ul style="list-style-type: none"> • Service to provide reasons for not meeting the standard to State/Territory managers (SCU/SAC). • State/Territory managers/SCU/SAC to assist the Service to develop a detailed management plan to address the failure. This plan should be managed /monitored by the State/ Territory managers (SCU/SAC). • The SAC (with a copy to relevant Program Manager) to notify the NQMC of Service’s failure to meet the standard, including the reasons for not meeting the standard and planned improvement strategies. • NQMC may advise the SAC (with copy to relevant Program Manager) of alternative strategies to assist the State/ Territory managers/SCU/SAC to improve the Service’s performance against the standard. • Service to provide data to demonstrate monitoring of requirements of standard.
Major or Significant risk	Level 2	<ul style="list-style-type: none"> • Service to provide reasons for not meeting the standard to State/Territory managers/SCU/SAC. • State/Territory managers/SCU/SAC to assist Service to develop a detailed management plan to address the failure. This plan should be monitored by the State/Territory managers (SCU/SAC). • Service to provide data to demonstrate monitoring of requirements of standard.
Moderate or Low or very low risk	Level 3	<ul style="list-style-type: none"> • Service to provide reasons for not meeting the standard to State/Territory managers/SCU/SAC. • Service to provide data to demonstrate monitoring of requirements of standard. • State/Territory managers/SCU/SAC to monitor Service’s management of performance against the standard.

The NQMC may become aware, through the annual data reports or otherwise, of quality issues in a particular Service. It retains the right to seek further information from the relevant SAC and/or SCU. It may make recommendations to the SAC and/or SCU to assist the Service in managing any areas of concern. The NQMC may hold an extraordinary review of a Service, upon the request of a SAC supported by documentation, or for other reasons. This could include a data audit and/or site visit to better assess the situation.

The preferred aim of the NQMC is to ensure Services are supported in maintaining their viability and quality. However, should a Service be operating in a manner that the NQMC considers unacceptable (for instance, in putting clients or staff at risk and/or not meeting a significant number of NAS), the NQMC will take necessary action to ensure the safety of consumers and the integrity of the Program.

Should the Service not be able to satisfactorily address the problems experienced, the NQMC will consider the following options:

- revising the accreditation level of the Service downwards;
- revoking the accreditation of the Service; or
- other, as appropriate.

12

DATA AUDITORS AND SITE VISITORS— SELECTION, APPOINTMENT TO AUDIT TASKS AND SITE VISITS, TRAINING AND ADMINISTRATIVE MANAGEMENT

The NQMC secretariat supports the NQMC to attract and maintain a skilled pool of data auditors and site visitors through coordination of the nomination and selection processes, development and maintenance of a register of appointees, and coordination of training.

12.1 APPLICATION PROCESS

Applications to be included on the national register of data auditors and site visitors should be made by letter to the NQMC secretariat for NQMC consideration and approval. The application will provide the NQMC with information addressing the selection criteria and competencies outlined below.

The NQMC, through its secretariat, will advise applicants in writing of the outcome of selection processes.

Note that existing data auditors and site visitors will be automatically included on the register unless the secretariat is informed otherwise.

12.2 SELECTION CRITERIA AND COMPETENCIES FOR NEW DATA AUDITORS OR SITE VISITORS

In their assessment of an application for appointment to the register of a data auditor or site visitor, the NQMC may consider the following:

- current working knowledge of BreastScreen Australia Program operations;
- knowledge and experience with other accreditation programs;
- understanding of the NAS and population based screening;
- understanding of quality improvement and risk management;
- skills, knowledge and experience in a data management role within BreastScreen Australia (for data auditors); and
- skills, knowledge or experience in any of the major roles within BreastScreen Australia eg. clinical, pathology, health promotion (for site visitors);

- referee reports as required;
- data audit/site visitor training assessment of competencies; and
- any other supporting information that will inform a decision as to the applicant's suitability for the role and/or training requirements.

It is also important that data auditors and site visitors:

- have a commitment to accreditation and quality improvement within BreastScreen Australia;
- have an understanding of the NAS and the Decision Tool;
- possess good communication skills;
- be flexible, supportive and aware that during data audits and site visits Service staff members may be stressed and anxious;
- possess conflict resolution and negotiation skills;
- respect the boundary of their role;
- are objective and do not have a conflict of interest (or are able to declare and manage any conflict of interest that may arise);
- maintain confidentiality and privacy in their professional dealings with BreastScreen Australia;
- are aware of best practice in relation to BreastScreen Australia Services; and
- accept responsibility, in the case of site visitors, as a team member and provide input accordingly.

12.3 REGISTER OF SITE VISITORS AND DATA AUDITORS

Following the implementation of the site visitor training program, the NQMC secretariat will develop and maintain a national register of suitably qualified data auditors and site visitors. The register will be a tool to assist the NQMC in assigning data auditors and site visitors for accreditation purposes. The information provided on the register will allow the NQMC to consider the best available mix of skills and experience when assembling a site visit team. It will also assist in managing the workloads of appointees, as details of data audit and site visit history will be available. The register will contain details of no less than 40 suitably qualified professional site visitors and no less than eight data auditors.

Appointment to the register is limited to people with a current working knowledge of BreastScreen Australia operations. Consumer representatives can be exempt from this initial requirement, although they are expected to gain Program knowledge through the site visitor training and involvement in accreditation activities. The NQMC retains the ability to consider appointing recently retired clinicians to the register on a case by case basis.

The register will include (but is not limited to) the following details for each appointee:

- name;
- qualifications;
- experience;

- curriculum vitae;
- contact details;
- assessment of competency for training programs completed;
- dates and details of data auditor/site visitor training attended;
- dates and details of data auditor/site visitor training updates;
- data audit/site visit history; and
- status of deed of confidentiality (ie. signed, received and filed).

All information provided for and kept on the register will be treated in a confidential manner. This information will be used for the purposes of managing training and ensuring that site visitors and data auditors are assigned according to Program requirements. The Program reserves the right to access contact details of site visitors and data auditors for purposes relating to the Program, such as to invite people to participate in training or consultative opportunities.

The NQMC has responsibility for assessing applications to the site visitor and data auditor register and advising the secretariat of the outcomes.

The NQMC appreciates the work commitments of appointees, particularly those site visitors employed in private practice. However, when agreeing to be included on the register, it is expected appointees will make a commitment to be available to undertake a minimum of three data audits or site visits over each two year period.

Appointment to the register is for an indefinite period. Should an individual resign from the Program, their appointment to the register will lapse three months after their resignation. For data auditors transferred or promoted to a position within the Program that has no relationship to data management, their appointment to the register will lapse three months from that time. Appointees may resign from the register at any time by informing the NQMC through the secretariat in writing of their decision.

The NQMC may review the appointment of site visitors and data auditors to the register. It has the authority to remove the name and details of a site visitor or data auditor from the register for reasons such as unsatisfactory performance, breach of conduct, or at the request of the site visitor or data auditor.

12.4 TRAINING

All site visitors must attend and complete the BreastScreen Australia site visitors' training program, and any relevant updates, whether they are experienced site visitors or new to the role. This includes SAC/SCU members who will undertake interim site visits.

It is recognised that it will take some time from implementation of training to completion by all eligible people. Therefore, one year from the time site visitor training becomes available,

a minimum of two people in every site visit team will be required to have completed the training. Once the training has been available for eighteen months, this number will rise to three members of each site visit team. By the second year, all members of any site visit team will be required to have completed training as a pre-condition to participating in a site visit.

Data auditors will receive training in the conduct of a data audit of a BreastScreen Australia Service at a jurisdictional level. This will be based on available data audit training materials, this Handbook and related BreastScreen Australia material.

The secretariat will ensure that all appointees to the register, including consumer representatives, have attended and completed the relevant training and updates.

It is recommended that jurisdictions consider the role of observers on site visits. For instance, observation of a site visit could be undertaken prior to formal training to give novices to the Program an understanding of the context. To minimise cost, observations could be done on a local basis, as the observer would be supernumerary to the site visit team. The same confidentiality provisions affecting the rest of the team apply to observers. Agreement by all members of the site visit team is required before an observer is given approval to attend.

The site visitor training program and observation of site visits are good developmental opportunities for all Program staff. It is recommended that consideration be given to broadening their use to people other than site visitors.

13

PAYMENT AND REIMBURSEMENT GUIDELINES FOR SITE VISITORS AND DATA AUDITORS

13.1 INTRODUCTION

This section outlines the roles and general processes applicable to the site visitors and data auditors for the payment and reimbursement for services to BreastScreen Australia. States and Territories have the flexibility to determine their own system of reimbursement based on the information given in this section.

It is recognised that different remuneration rates apply in various jurisdictions, and that Remuneration Tribunal rates are adjusted over time. The figures in this section are suggested minimum amounts based on Remuneration Tribunal rates at the time of writing. It is critical to the ongoing success of the BreastScreen Australia accreditation system to adequately reimburse and remunerate site visit team members for their valuable contribution to Program quality.

The State or Territory SCU applying for accreditation is responsible for:

- payment of honorariums to site visitors not employed by BreastScreen Australia or by a State or Territory Government;
- reimbursing the travel, accommodation and incidental costs of all site visitors and data auditors;
- informing site visitors and data auditors in writing of the arrangements for payment of honorariums and reimbursements before the site visit commences; and
- making timely payments, preferably in advance, or as soon as possible upon receipt of a claim, so as not to disadvantage people who have supplied their services for the advantage of the BreastScreen Australia Program.

13.2 PAYMENT OF HONORARIUMS

Site visitors and data auditors who are **not** salaried staff of a BreastScreen Australia Service, a State/Territory Government or local government agency receive remuneration, in the form of an honorarium, for the provision of services to BreastScreen Australia. Note that part time State and Territory government employees may be eligible for honorariums should they undertake a site visit at a time they would not usually be working for that employer.

The honorarium may be paid either to the individual or their organisation, and this is to be determined by the SCU on a case by case basis.

The honorarium may be determined using the Remuneration Tribunal Determination 2003/03 for part-time officers in the Health and Ageing and Community and Family Services Portfolios. (Ref Remuneration Tribunal Determination 2003/ 03, p20, <http://www.remtribunal.gov.au/determinationsReports/byYear/2003dets/2003-03Consolidated.pdf>)

Honorariums should be determined based on the site visitor’s expertise, with specialists (eg. surgeons and radiologists) receiving a Category 3 Member payment as highlighted in Table 9 below. Chairs of site visit teams receive the Category 3 chair’s payment and other site visit team members (eg. consumer representatives) receive a Category 2 Member payment.

Table 9: Payment levels for site visit teams (per day)²

Office	Category 1 \$	Category 2 \$	Category 3 \$
Chair	307	416	503
Member	230	307	448

To ensure site visitors and data auditors with a high level of expertise in their field are attracted to participate on site visits a reasonable honorarium is required. A Category 3 payment is proposed as a reasonable rate to cover expenses for a ‘day out of clinic’ for specialists.

13.3 CALCULATION OF FEES³

Periods of three or more hours are classified as a day in calculating the amount due. A site visitor may be paid in respect of site visits of less than three hours subject to the following conditions:

- a) for periods aggregating less than two hours, an amount equal to two-fifths of a daily fee;
- b) for periods of two hours or more, but less than three hours on any one day, an amount equal to three-fifths of a daily fee;
- c) the maximum payment in respect of any one day shall be the appropriate daily fee;
- d) eligibility for each payment shall be certified by the Service Manager (in consultation with the chair of the site visit team if there is any concern as to eligibility). Certification decisions will take into account reasonable travelling time.

² Derived from Remuneration Tribunal Determination 2004/12 (with effect from 1.07.04)

³ Derived from <http://www.remtribunal.gov.au>

A site visit of less than three hours may occur in the case of an interim site visit, or if a full site visit takes some time over a full day or day's reckoning, such as say, one day and two hours.

Time spent travelling amongst the various units within a Service is to be included in calculating the hours worked.

13.4 REIMBURSEMENT OF EXPENSES (EG. TRAVEL, ACCOMMODATION AND INCIDENTAL ALLOWANCE)

All site visitors and data auditors are eligible to be reimbursed for expenses related to undertaking services for the Program. Legitimate expenses include airfares, accommodation, meals and incidentals (including bus/taxi fares and car parking) incurred during the period of the site visit or data audit.

Each jurisdiction has the flexibility to determine its own system of reimbursement based on the rates of travelling allowance provided in Table 10 below. For instance, a State or Territory, through its SCU, may decide to adopt models such as:

- providing eligible site visitors and data auditors with travel allowance (inclusive of accommodation, meals and incidentals) at the rates shown in Table 10 below;
- arranging and paying directly for travel and/or accommodation for eligible site visitors and data auditors and providing reimbursement for other expenses on receipt of original receipts;
- advising eligible site visitors and data auditors to arrange their own travel and accommodation and making reimbursement for these plus meals and any incidental costs on receipt of original receipts; and
- other arrangements as per local practice.

If using options such as b) and c) above, original receipts are required prior to reimbursement. The expenditure approver should be satisfied that the expenses were incurred as a result of site visit related business.

If there is any doubt as to whether proposed expenditure is a legitimate expense, site visit team members should, through the site visit chair, obtain 'approval in principle' from the SCU before incurring the expenditure. It should not be expected that approval be automatically granted.

It is the SCU's responsibility to ensure that site visitors and data auditors are informed in writing of the arrangements for payment of honorariums and reimbursements before the site visit commences.

13.5 TRAVEL ALLOWANCE

Travel allowance rates are taken from Remuneration Tribunal Determination 2004/03 and can be viewed at <http://www.remtribunal.gov.au/>. See the website for more information, including rates for specified country centres. It is recommended that travel allowance be paid at Tier 3 rates, equivalent to economy class travel.

Table 10: Travel allowance rates for site visitors and data auditors.

Adelaide	Brisbane	Canberra	Darwin	Hobart	Melb	Perth	Sydney	Other than capital city
\$208	\$202	\$186	\$203	\$190	\$236	\$203	\$239	\$146

14

SUMMARY OF ROLES AND RESPONSIBILITIES IN ACCREDITATION

14.1 THE SCREENING AND ASSESSMENT SERVICE (THE SERVICE)

The Service must:

- ensure that it has the current set of NAS and is complying with or working towards meeting those standards;
- also be familiar with other key BreastScreen Australia accreditation documents including the Decision Tool, the site visitors' training manual, the accreditation forms, the data audit guidelines and related training materials;
- implement a continuous quality improvement program that is complementary to and consistent with the requirements of the BreastScreen Australia accreditation process;
- undertake a self assessment against the NAS as part of the application for accreditation, and use self-assessment as an integral part of its quality improvement program;
- ensure that the completed application forms and supporting documentation are submitted to the SCU, for forwarding to the SAC, in agreed time lines;
- ensure that the documents submitted as part of the Service's accreditation application are based on the NQMC prescribed reporting format;
- take any necessary steps recommended by the SAC or NQMC to achieve accreditation;
- notify the SAC immediately of changes which may affect compliance with current accreditation standards or requirements; and
- provide the NQMC with quantitative annual data (including explanations of all unmet standards) and performance reports between accreditation reviews based on the NAS, using the prescribed reporting format.

14.2 THE STATE COORDINATION UNIT (SCU)

The SCU:

- is responsible, in conjunction with the SAC, for the planning and coordination of accreditation of Services within the State or Territory in the agreed timeframes, and notification to the SAC if these timeframes are not able to be met;

- works with the SCU and Service to manage any quality issues that arise;
- acts as a central coordination point for all accreditation documentation. The communication pathway is usually from the Service Manager to the SCU to the SAC and then the NQMC. The NQMC liaises directly with the SAC, which then provides information to the SCU and the Service;
- ensures a notification of commencement form is completed before a Service commences screening;
- ensures that pre-commencement visits are undertaken where required;
- provides all relevant documents to the Service to support implementation and measurement of the standards well in advance of the scheduled accreditation process (including the NAS and relevant forms);
- consults with Services and provides advice on compliance with the NAS;
- arranges interim data audits and interim site visits, liaising with the secretariat as required;
- requests the selection of a data auditor and formation of a site visit team at appropriate times to ensure accreditation timelines are met;
- provides the data auditor with accreditation documentation for consideration no less than 3 weeks prior to the data audit;
- provides the site visit team with accreditation documentation for consideration, including the data auditor's report, no less than three weeks prior to a site visit;
- works with the Service Manager to develop a program prior to the site visit;
- ensures an assessment clinic is included in the site visit schedule;
- arranges a briefing for members of the site visit team either prior to the site visit, eg. by teleconference or meeting where possible, or at the beginning of the site visit;
- arranges payment of allowances to eligible site visitors and data auditors;
- reviews all applications, site visit reports and data audit reports and ensures all necessary documentation is forwarded to the SAC; and
- provides secretariat support to the SAC.

14.3 THE STATE ACCREDITATION COMMITTEE (SAC)

The role of the State Accreditation Committee is to oversee accreditation activities within its State or Territory and to work with members of the SCU and with Service providers to support the provision of quality services within BreastScreen Australia.

The SAC is responsible for:

- ongoing monitoring of Service performance within the jurisdiction;
- working with the SCU and Service to manage any quality issues that arise;
- developing a jurisdictional annual plan for spacing accreditation against which Services can align their accreditation needs;
- notifying accredited Services eight months prior to the end of their term that an application is required;

- notifying the NQMC secretariat if accreditation timeframes are not able to be met and/or if there are significant quality issues with a Service;
- liaising and communicating between the NQMC and the SCU;
- participating in pre-commencement visits to new Services and units;
- determining whether interim site visits and interim data audits are required for new units;
- ensuring all accreditation documentation is submitted to the NQMC as required (ie. material is comprehensive, complete and timely);
- working with the SCU to ensure applications for accreditation fit into the NQMC quarterly meeting schedule; and
- making recommendations to the NQMC on the accreditation of Services.

Note that not all States and Territories have established a SAC, and in these instances, it is recommended that another jurisdiction's SAC undertake the role.

14.4 THE NQMC

The NQMC:

- oversees the BreastScreen Australia accreditation process;
- considers the accreditation documentation and all aspects of a Service's performance, and makes decisions on the accreditation status of Services, using the Decision Tool for accreditation decision making, in consultation with the SAC and site visit team, as appropriate;
- monitors, on an annual basis, performance of Services against the NAS in the period between accreditation reviews;
- liaises with the State and Territory accreditation committees;
- manages the development and review of the NAS in consultation with other BreastScreen Australia bodies as appropriate;
- develops and reviews the accreditation documentation, site visitor training and process;
- considers accreditation applications from Services in the context of all supporting material provided, including the data auditor's and site visitors' reports and the recommendation of the SAC;
- decides whether or not a Service should be accredited and the level of accreditation to be granted to the Service;
- considers any appeals on decisions of accreditation, reviewing its original decision and recommendations;
- instructs the NQMC secretariat to convene an Appeals Committee, if it decides not to revise its original decision, and refers the matter to the Appeals Committee for its consideration;
- instructs the NQMC secretariat to advise the appellant in writing of the appeal outcomes; and
- adheres to administrative law principles in making decisions about accreditation of Services.

14.5 NQMC SECRETARIAT

The NQMC secretariat will:

- provide secretariat support to the NQMC;
- maintain the national register of site visitors, data auditors and Appeals Committee members;
- appoint data auditors from those included on the register, upon request of the SCU;
- appoint site visit teams from those included on the register, upon request of the SCU;
- ensure all site visitors, data auditors and Appeals Committee members have signed appropriate confidentiality and declaration of interest form and maintain a copy of the signed forms (the Commonwealth holds the originals);
- upon appointment to an accreditation task, remind data auditors and site visitors of their obligations relating to confidentiality/conflict of interest;
- co-ordinate, promote and seek nominations for site visitor training including training updates;
- arrange the site visit team for the site visits for all Services;
- provide performance information on accreditation to the Australian Screening Advisory Committee;
- facilitate the development of all processes and documentation associated with accreditation;
- process application forms and provide written advice to Services via the SACs concerning decisions of the NQMC;
- organise training for site visitors, data auditors and Appeals Committee members, and training updates for registered site visitors and data auditors as required;
- compile a statement of reasons for each accreditation decision made by the NQMC including relevant finding of fact, the evidence on which those findings were based and the reasons for the decision;
- provide the accreditation certification and maintain a record of all certificates issued;
- advise the SAC in writing of the NQMC's decision on accreditation;
- provide a Certificate of Accreditation to the SAC for provision to the Service; and
- maintain a record of the accreditation status of each Service and send reminders to the SCU before accreditation is due;
- provide secretariat support to the Appeals Committee; and
- advise the appellant in writing of the appeal outcomes.

14.6 THE DATA AUDITOR

It is the role of the data auditor to:

- ensure that the Service has a current and complete policy and procedures manual based on the NAS and the National Data Dictionary and the data audit checklist;
- ensure that there are appropriate data flows and that the processes and procedures observed during the data audit are congruent with the policy and procedures manual;

- ensure as comprehensively as possible that the data reported against the NAS is timely and accurate;
- ensure that there is a supportive environment for the policies, processes and procedures that relate to data management;
- gauge the level of understanding by staff of the relevant policies, processes and procedures that relate to data management; and
- be totally independent of the Service applying for accreditation.

14.7 THE SITE VISIT TEAM

The whole team

Members of the site visit team are responsible for:

- ensuring their skills are up to date and relevant to the tasks;
- signing a deed of confidentiality before undertaking any accreditation task;
- notifying the secretariat if they have a conflict of interest related to a particular accreditation task or to the Program;
- making themselves available for site visitor training; and
- making time to undertake all the components of a site visit, including reading of documentation and engaging in a preliminary team meeting or teleconference, the actual visit, and any activities to finalise the visit, including completion and sign off of the report and providing feedback to the NQMC if required.

The chair of the site visit team

As outlined in Section 7.2, the NQMC secretariat will, prior to the site visit, formally nominate one member of the team to act as the chair. As the site visitor training will ensure that all members of the site visit team are skilled in the role of chair, this role will, over time, be shared among those on the site visitor register.

The responsibilities of the chair of the site visit team include:

- working with the SCU to ensure the site visit team has a teleconference or meeting wherever possible before the visit, or at the commencement of the visit;
- reminding site visitors of their conflict of interest/confidentiality responsibilities before a visit;
- introducing the site visit team to the Service staff and informing them of the days' proceedings before the visit begins and following the visit, address all staff thanking them for their cooperation and assistance during the visit, if the chair chooses;
- encouraging all site visit team members to contribute to every aspect of the site visit and facilitate the team to review the processes and activities of the Services in relation to the NAS;

- coordinating the report writing relating to the findings of the site visit in consultation with the other site visit team members; and
- forwarding the signed report of the visit to the SCU within two weeks of the visit, for provision to the Service Manager and the SAC.

15

BREASTSCREEN AUSTRALIA— CONTINUALLY IMPROVING

Quality management and improvement are ongoing processes and will continue to evolve along with the BreastScreen Australia Program. For instance, from 2005, the introduction of new forms and site visitor training is expected to support consistency and quality across the Program. New products such as these will be evaluated and modified over time to meet the needs of the Program and its clients. In addition, data will continue to be collected on the NAS and their implementation to inform monitoring and eventual review of the standards themselves.

Program Managers have an established mechanism through their regular jurisdictional meetings to discuss accreditation issues and to provide feedback to the NQMC on quality and policy issues. Any other stakeholder, whether a client, staff member, data auditor, site visitor or other, has a right to provide feedback on any aspect of the accreditation process. To make this process easier, a form is available on the website <http://www.breastscreen.info.au> to allow people to make direct inquiries or suggestions about BreastScreen Australia.

Some of the ways the feedback form could be used include:

- a site visitor making comments about a specific site visit or the training program;
- a data auditor commenting on a strength/weakness of a new form;
- a Service manager or staff member commenting on the professionalism of a site visit team/member;
- any stakeholder raising suggestions for improvement; and
- a consumer requesting information about the accreditation process.

Issues raised will be addressed immediately where possible. More complex policy issues will be referred to the NQMC for decision. Should feedback indicate specific issues in a jurisdiction, the matter may be referred directly to the relevant SAC for action. Should feedback identify an individual site visitor, the feedback will be referred directly to the individual to allow the right of reply. The SAC will advise and liaise with the NQMC to resolve the issue. As well as identification of issues and problems, we welcome advice on what is working well.

The accreditation status of Services will be posted on the website. As well as providing information to the community, this will allow site visitors to see the accreditation outcomes for the Services they have visited.

FLEXIBILITY IN ACCREDITATION—A CASE STUDY

Introduction

The focus of the BreastScreen Australia quality improvement program is ensuring that minimum standards are maintained and that the Program pursues excellence by continually developing strategies to review and improve activities. Services operate in very different contexts across (and often within) States and Territories. For instance, they are subject to the effects of different demographics, geography and infrastructure. In recognition of this diversity, the Program is able to accommodate some flexibility in its accreditation process to meet local needs.

The NQMC will consider options for Service's accreditation other than those outlined in this handbook. In putting a case to the NQMC for a variation from usual procedure, a SAC should provide information that shows:

- how the intent of the accreditation process will be met (ie. how quality will be maintained or improved through the proposal);
- how quality will be measured through the NAS;
- any risks involved and the strategies to be used to manage these; and
- the advantages of the proposal.

The following case study is an example only. A Service considering a similar approach will need to consider how to best ensure quality in its specific situation and consider the most appropriate use of the NAS and accreditation processes in that context. It must provide information for NQMC consideration before implementation.

A case study—mobile screening Services in Victoria

This information is included with the permission of BreastScreen Victoria

The original situation

BreastScreen Victoria includes the Mobile Screening Service (MSS) which provides breast cancer screening to women in isolated areas. It was auspiced, or hosted, by different Screening and Assessment Services depending on its location. Standards relating to the mobile Service were reported as part of the accreditation report of each host Service, all of which were accredited.

Triggers for change

A second mobile screening Service was about to become operational. In addition, a site visit was held, and the site visitors' comments on the organisational structure supporting the MSS reflected areas the SCU (known as the BCU or BreastScreen Coordination Unit in Victoria), was working to improve.

The outcome

The SCU developed a new structure that came into effect on 1 March 2004. The SAC put to the NQMC, at its May 2004 meeting, a process for accreditation of the mobile screening Services within this structure. The SAC demonstrated how this would address the issues raised by the site visit team and showed how performance would be measured against the NAS. The NQMC agreed to the proposal. As with all accreditation matters, this will be monitored within the jurisdiction and by the NQMC to ensure it effects the desired quality outcomes.

The following sections are part of the information provided to the NQMC in support of this proposal.

SECTION ONE: MOBILE SCREENING SERVICES AND HOST SCREENING AND ASSESSMENT SERVICE (SAS)

Existing Mobile Service

Auspice SAS	SAS Accredited until	Site visited
Maroondah	August 2005	Mansfield Alexandra Wangaratta
Central Highlands and Wimmera	November 2007	Birchip Hamilton
Bendigo	February 2008	Echuca Kerang Swan Hill
Gippsland	November 2004	Mallacoota Orbost Foster Leongatha Wonthaggi

New Mobile Service (to commence August 2004)

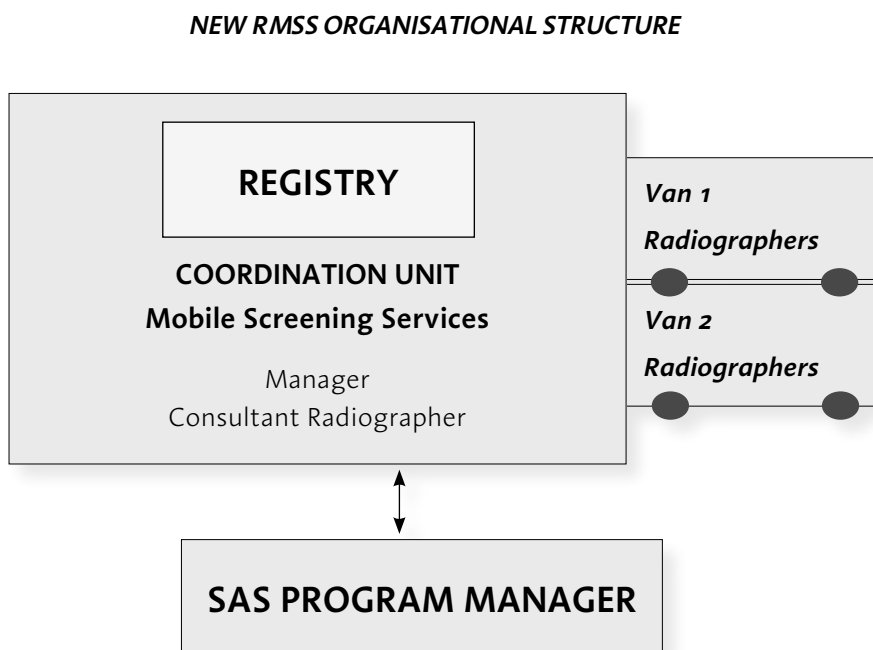
Auspice SAS	SAS Accredited until	Site visited
North Western	August 2005	Broadford Melton Bacchus Marsh Melton Seymour Sunbury Gisborne Kyneton Port Phillip
Maroondah	August 2005	Whittlesea Belgrave

SECTION TWO: RESPONSES TO SITE TEAM RECOMMENDATIONS

Recommendation

There is a central place for coordination of all aspects of the MSS including day to day operational management, servicing and routine maintenance, scheduling/ itineraries and more importantly line management of the staff, including a consistent approach to performance appraisal, training and development.

Response



- Management of both the current and the proposed new mobile screening Services has been centralised within the BreastScreen Coordination Unit (BCU) as outlined in the organisational structure above.
- It is expected this will address the issues raised by the site team, particularly in regard to support and management of the van staff.
- The Consultant Radiographer will now review 10 films from each van radiographer weekly. This is in addition to the NAS required film quality assurance which will still be undertaken by the designated radiographer based at the Service auspicing the mobile Service for each visit.
- Forward planning has been undertaken to ensure the mobile Service radiographers are released for training opportunities. Training and professional development undertaken in 2004 to date includes:
 - first aid training
 - training in using Windows based systems
 - positioning workshop
 - attendance at assessment clinics at host Service
 - attendance at radiographer review meetings at host Service.

Recommendation

The BCU/SAC give consideration to a review of the state-wide MSS when the proposed second unit is commissioned (see Section Three).

Response

1. Initial accreditation assessment

Both the existing mobile screening Service and the new mobile screening Service to undergo an accreditation assessment in October 2004. One van will be located in Wangaratta and the other in Melton.

This assessment will include:

- Report on data and non-data items as listed below
- Accreditation site visit by an interstate team comprising a Program Manager and Radiographer
- Site team to
 - Examine the data and non-data report
 - Examine the Mobile Service Manual
 - Visit each van
 - Meet with all van radiographers
 - Meet with BCU Mobile Screening Services staff including the Mobile Services Manager and Consultant Radiographer.

2. Site visit report forwarded to the SAC/SCU and then the NQMC

3. NQMC consideration of the accreditation application

- NQMC to consider granting accreditation based on report
- Mobile Services to be considered accredited while holding accreditation status granted by NQMC, and while operating under the auspices of an accredited BreastScreen Service.

SECTION THREE: ANNUAL PERFORMANCE SUMMARY FOR MOBILE SCREENING SERVICE AGAINST NATIONAL ACCREDITATION STANDARDS

CANCER DETECTION

Level	NAS number	NAS description
3	2.10.2	The Service ensures: <ul style="list-style-type: none"> • that mammographic screening examinations consist of the two standard views (that is, cranio-caudal and medio-lateral oblique) • documentation of reasons for any deviation from the standard two views • implementation of a protocol for adequate examination of women with internal breast prostheses.
3	2.10.3	The overall repeat rate for the Service is <3% of all screening films.
3	2.10.4	The Service demonstrates annually that each radiographer achieves 50% or greater P or G ratings in a PGMI evaluation of 50 randomly selected film sets as outlined in Appendix M.

INFORMATION GIVEN

Level	NAS number	NAS description
2	3.3.1	Women are offered the opportunity to ask questions in private before giving consent for any procedure. Health care providers are available to answer any clinical questions.
2	3.3.3	Written consent is obtained from all women before: <ul style="list-style-type: none"> • the screening mammogram • investigations at the assessment visit.

MANAGEMENT

Level	NAS number	NAS description
2	2.9.1	X-ray systems, premises and users meet radiation protection regulations.
2	2.9.2	Breast imaging quality control test equipment meets the minimum standards specified in Appendix L.
2	2.9.3	Quality control procedures that meet the standards specified in Appendices K and H are implemented.
2	2.9.4	Breast imaging systems, including ancillary items, meet: <ul style="list-style-type: none">• manufacturer’s specifications• performance standards as specified in Appendices H and I.
2	2.9.5	Acceptance and annual testing of mammography systems is performed by, or under the close supervision of suitably qualified and experienced persons as specified in Appendix J.
2	2.9.6	Preventative maintenance and repair of imaging equipment meets manufacturer’s recommendations or other appropriate standards.
2	2.10.1	Mammography is performed by diagnostic radiographers who are appropriately trained and supervised as specified in Appendix J.
2	2.10.5	The Service has a designated radiographer who is appropriately qualified and who is responsible for all aspects of quality assurance in radiography as outlined in Appendix N.
2	2.10.6	The designated radiographer implements a process for providing ongoing assessment and feedback to radiographers in all units (see Appendix K) about the quality of screening films using criteria such as those used in the PGMI evaluation system outlined in Appendix M.
2	2.11.1	Film identification complies with relevant radiation licensing regulations. Each film or hardcopy image is clearly marked with the date and sufficient information to identify the client and enable correct interpretation. All identifying information is on the film and is transferred to each copied film.

MANAGEMENT CONT

Level	NAS number	NAS description
2	2.11.2	The Service demonstrates the identification of the radiographer and X-ray machine used for each screening mammogram.
2	4.3.1	All new and existing staff meet the relevant expertise, experience and training standards outlined in Appendix J.
2	4.3.2	All professional staff undertake continuing education and meet the continuing medical requirements of the professional bodies which represent their discipline.
2	4.3.4	All staff receive appropriate orientation and training within three months of commencement of employment at the Service.
2	4.3.6	All staff undergo annual performance appraisal, where they have the opportunity to identify any training needs that have not been met and agree to a plan for addressing these needs.
2	4.4.1	The Service has systems in place to ensure that screening unit staff work closely with the assessment unit to ensure an integrated Service, including: at least one of the film readers will be part of an assessment team in the Program. There will be liaison between staff in the screening units and assessment centre.
2	4.6.3	All staff are trained to ensure an understanding of the policies, protocols and procedures of the Service.
2	4.7.1	The Service implements protocols to meet relevant State/Territory and national infection control standards.
2	4.7.2	The Service implements protocols to meet relevant State/Territory and national occupational health and safety standards.
2	4.9.1	All screening units within the Service are linked to a specific assessment centre
2	4.11.2	All staff sign a confidentiality form outlining their responsibilities and obligations upon commencement of employment at the Service and each year thereafter.
3	4.3.5	In-Service training, of at least six hours, is provided to all staff annually.