doi: 10.1111/hex.12300

Analysing 'big picture' policy reform mechanisms: the Australian health service safety and quality accreditation scheme

David Greenfield PhD,* Reece Hinchcliff PhD,† Margaret Banks MHA,‡ Virginia Mumford MBBS,§ Anne Hogden PhD,¶ Deborah Debono BA (Psych Hons),** Marjorie Pawsey MBBS,† Johanna Westbrook PhD†† and Jeffrey Braithwaite PhD‡‡

*Associate Professor, †Visiting Research Fellow, §Doctoral Scholar, ¶Research Fellow, **Research Officer, ‡‡Professor and Director, Centre for Clinical Governance Research, Australian Institute of Health Innovation, University of New South Wales, Sydney, NSW, ‡Senior Program Director, Australian Commission on Safety and Quality in Health Care, Sydney, NSW and ††Professor and Director, Centre for Health Systems and Safety Research, Australian Institute of Health Innovation, University of New South Wales, Sydney, NSW, Australia

Correspondence
David Greenfield PhD
Associate Professor
Faculty of Medicine
Australian Institute of Health Innovation
University of New South Wales
AGSM Building
Sydney
NSW 2052
Australia
E-mail: d.greenfield@unsw.edu.au

Accepted for publication
9 October 2014

Keywords: accreditation, health policy, healthcare quality assurance, healthcare reform, policy development

Abstract

Background Agencies promoting national health-care accreditation reform to improve the quality of care and safety of patients are largely working without specific blueprints that can increase the likelihood of success.

Objective This study investigated the development and implementation of the Australian Health Service Safety and Quality Accreditation Scheme and National Safety and Quality Health Service Standards (the Scheme), their expected benefits, and challenges and facilitators to implementation.

Methods A multimethod study was conducted using document analysis, observation and interviews. Data sources were eight government reports, 25 h of observation and 34 interviews with 197 diverse stakeholders.

Results Development of the Scheme was achieved through extensive consultation conducted over a prolonged period, that is, from 2000 onwards. Participants, prior to implementation, believed the Scheme would produce benefits at multiple levels of the health system. The Scheme offered a national framework to promote patient-centred care, allowing organizations to engage and coordinate professionals' quality improvement activities. Significant challenges are apparent, including developing and maintaining stakeholder understanding of the Scheme's requirements. Risks must also be addressed. The standardized application of, and reliable assessment against, the standards must be achieved to maintain credibility with the Scheme. Government employment of effective stakeholder engagement strategies, such as structured consultation processes, was viewed as necessary for successful, sustainable implementation.

Conclusion The Australian experience demonstrates that national accreditation reform can engender widespread stakeholder support, but implementation challenges must be overcome. In particular, the fundamental role of continued stakeholder engagement increases the likelihood that such reforms are taken up and spread across health systems.

Introduction

Despite international efforts and investments over several decades, health care causes significant preventable harm to patients, worldwide.[1–3] Health professionals, including clinicians, managers and researchers, are increasingly applying ideas, strategies and initiatives, the purpose of which is to reduce harm and improve efficiency and the delivery of care.[4] This orientation is reinforced by consumer demands for improved safety and quality in health care. At times, governments respond using policy levers.[5,6] Introducing or revamping national accreditation reform is one type of common policy response.[7,8] Accreditation programmes are reputed to stimulate systems-level improvement by promoting uptake of optimal, evidence-based governance and clinical standards.[9,10]

In Australia, in 2013, systems-level accreditation reform recently occurred with the implementation of the Australian Health Service Safety and Quality Accreditation (AHSSQA) Scheme (the Scheme). The effectiveness of the Scheme, overseen by the Australian Commission on Safety and Quality in Health Care (ACSQHC), was dependent on five interrelated stakeholder groupings with assigned roles (Table 1).

Central to the reform has been the development and application of National Safety and Quality Health Service (NSQHS) Standards. The NSQHS Standards are a set of 10 evidence-based improvement strategies for health service organizations, which focused on areas considered essential to improving patient care, such as promoting consumer engagement (Standard 2) and reducing infection rates (Standard 3) (Table 2).[11] Each Standard has a set of criteria, and for each criteria, a series of actions are required to be fulfilled. Each action is designated as either core, and critical for safety and quality, or developmental, denoting aspirational targets.[12] The NSQHS Standards are assessed against a three-point rating scale: 'not met' – the actions required have not been achieved; 'satisfactorily met' – the actions required have been achieved; and 'met with merit' – in addition to achieving the actions required, measures of good-quality and a higher level of achievement are evident. In exceptional circumstances, an action may be rated as 'not applicable' in a specific context.[13] To achieve accreditation, all core actions (209 for hospitals and 208 for day procedure centres) must be demonstrated by health services, and in doing so, each standard satisfied.

The impact of this national reform is significant and on-going. At present, there is limited publicly available international research evidence to guide agencies responsible for developing and implementing such programmes.[14,15] This knowledge gap compels policymakers to rely on their own unfolding experience, expert opinion and small-scale pilot evaluations when undertaking national accreditation reforms.[16] Our study examined the Australian experience of national reform involving the new accreditation system being applied to all acute care health services. This multimethod qualitative study investigated stakeholder perceptions of the development, expected benefits, challenges and enablers of the Scheme. Challenges and facilitation factors arising from the Australian experience are outlined. The key findings can inform strategic design and implementation of comparable international reforms, increasing their potential to achieve patient safety benefits.

Table 1 Stakeholders involved in, and activities undertaken for, key elements of the AHSSQA Scheme[42]

Stakeholders	Element	Activities
Health Ministers	Overall responsibility for the governance of the Scheme	Endorse the NSQHS Standards Receive regular information on the health system's performance against the Standards
ACSQHC	Body charged with the task of implementing and managing the Scheme	A National Coordination Program undertakes the following: development and maintenance of the NSQHS Standards (revision due in 2015); advising Health Ministers on the scope of the Scheme; approval of accrediting agencies to assess against the NSQHS Standards; on-going liaison with regulators and approved accrediting agencies to promote improvement to the Scheme; and annual reporting to Health Ministers on safety and quality across the health system.
State, territory and Commonwealth regulatory agencies (regulators)	Manage the operation of the accreditation process for their jurisdiction	The regulators adopt the NSQHS Standards and determine which health services are to be accredited. They receive relevant accreditation data, sensitive to operational context, as a performance measure of health services. Where the Standards are not met, regulators commence a series of escalating actions to remediate the service and ensure the NSQHS Standards are eventually met.
Health services	Provide health care to individuals and the community	Health services assess against the NSQHS Standards and select an approved accrediting agency to assess their compliance.
Approved accreditation agencies	Assess health services against the NSQHS Standards	Accrediting agencies apply and are granted approval if they meet ACSQHC criteria. As a minimum, this involves being accredited by an internationally recognized certification body. Approved accrediting agencies assess health services against the NSQHS Standards. They provide accreditation information to the health services, regulators and the ACSQHC and agree to work with the ACSQHC to ensure national consistency in the interpretation of the NSQHS Standards and assessment processes.

Methods

This study forms one part of the ACCREDIT (Accreditation Collaborative for the Conduct of Research, Evaluation and Designated Investigations through Teamwork) Project, led by researchers at the Australian Institute of Health Innovation, University of New South Wales (UNSW).[17–20] Collaborators include prominent accreditation agencies from the Australian acute, primary and aged care sectors: The Australian Council on Healthcare Standards; Australian General Practice Accreditation Limited; and the Australian Aged Care Quality Agency (formerly the Aged Care Standards and Accreditation Agency). Federal and State Government safety and quality agencies are also represented, including the ACSQHC and the New South Wales Clinical Excellence Commission. The UNSW Human Research Ethics Committee approved the study (HREC Approval No: 10274). Written consent was gained from participants prior to participation in the study.

A multimethod investigation was conducted of the implementation, enabling triangulation of findings.[21] Semi-structured interviews were employed, accompanied by document analysis and observational research (Table 3). The utility of mixed qualitative methods for examining

Table 2 Summary of the NSQHS Standards[32]

Standard	Descriptions
1. Governance for safety and quality in health service organizations	The quality framework used by organizations to implement safe systems.
2. Partnering with consumers	Systems and strategies used to create a consumer-centred health system by including consumers in the development and design of quality health care.
3. Preventing and controlling health-care-associated infections	Systems and strategies used to prevent infection of patients within the health-care system and to manage infections effectively when they occur to minimize the consequences.
4. Medication safety	Systems and strategies to ensure clinicians safely prescribe, dispense and administer appropriate medicines to informed patients.
5. Patient identification and procedure matching	Systems and strategies used to identify patients and correctly match their identity with the correct treatment.
6. Clinical handover	Systems and strategies used for effective clinical communication whenever accountability and responsibility for a patient's care is transferred.
7. Blood and blood products	Systems and strategies for the safe, effective and appropriate management of blood and blood products so that patients receiving blood are safe.
8. Preventing and managing pressure injuries	Systems and strategies used to prevent patients developing pressure injuries, and employment of best practice management when pressure injuries occur.
9. Recognizing and responding to clinical deterioration in acute health care	Systems and processes to be implemented by health services to respond effectively when patients' clinical condition deteriorates.
10. Preventing falls and harm from falls	Systems and strategies used to reduce the incidence of patient falls in health services, and employment of best practice management when falls do occur.

health policy reform processes has been established.[22] Data collection focused on three issues: how the Scheme was developed; expectations regarding its benefits; and perceptions of key implementation challenges and facilitation factors. The ACSQHC website was reviewed for publicly available information concerning the Scheme. Eight reports were analysed to identify relevant information regarding the main study foci.

Twenty-five hours were allocated to observing the operation of two committees, the 'Regulators Working Group' and the 'Accrediting Agencies Working Group', convened by the ACSQHC, which led the design of the Scheme and facilitated its implementation. The 'Regulators Working Group' comprised 20 representatives of agencies responsible for the coordination of acute public and private health services in each Australian state and territory. The 'Accrediting Agencies Working Group' involved representatives of 16 accreditation agencies operating in Australia. In all, five committee meetings were observed, and in particular, key issues regarding implementation challenges and facilitators were noted. The observational research was conducted by two researchers with experience applying ethnographic methods in health care.[23–25]

Interviews were undertaken with a cross section of Australian health-care accreditation stakeholders. In late 2011, management teams of accreditation agencies involved in ACCREDIT provided the contact details of representatives from organizations they viewed as key stakeholder groups, such as government quality improvement agencies, accreditation agencies and health-care professional associations. Invitations were emailed to the representatives inviting them to participate in the study. A convenience sample of health-care professionals was recruited at accreditation educational workshops held in every Australian state and territory during early 2012. Also arranged at this time was a group interview with consumer representatives from a peak national organization representing the rights, needs and interests of older Australians.

Table 3 Overview of methods, participants and data

Study methods	Data sources Reports	
Document analysis	Australian Commission on Safety and Quality in Health Care (ACSQHC) (2006). Discussion paper: national safety and quality accreditation standards. Sydney, Australia, ACSQHC. Australian Commission on Safety and Quality in Health Care (ACSQHC) (2010). National safety and quality health service standards and their use in a model national accreditation scheme: decision regulatory impact statement. Sydney, Australia, ACSQHC. Australian Commission on Safety and Quality in Health Care (ACSQHC) (2011). National safety and quality health service standards. ACSQHC. Sydney, Australia, Commonwealth of Australia. Australian Commission on Safety and Quality in Health Care (ACSQHC) (2012). Accreditation outcome results and evidence of implementation of the National Safety and Quality Health Service (NSQHS) Standards. Sydney, Australia, ACSQHC. Australian Commission on Safety and Quality in Health Care (ACSQHC). (2013). 'Development of the national safety and quality health service standards'. Retrieved 13 May, from http://www.safetyandquality.gov.au/our-work/accreditation/development-of-the-standards-and-model-national-accreditation-scheme/. Australian Commission on Safety and Quality in Health Care (ACSQHC) (2013). Hospitals: core and developmental actions. National Safety and Quality Health Service Standards. Sydney, Australia. Australian Council for Safety and Quality in Health Care (ACSQHC) (2003). Standards setting and accreditation literature review and report. ACSQHC. Canberra, Australia. Australian Council for Safety and Quality in Health Care (ACSQHC) (2003). Standards setting and accreditation systems in health: consultation paper. ACSQHC. Canberra, Australia.	
	Activities	
Observations	ACSQHC Regulators Working Group: 20 representatives ACSQHC Accrediting Agencies Working Group: 16 representatives	25 h of non-participant observations
	Stakeholder categories	Interviews and participants (*n*)
Interviews	Health-care professionals	10 (51)
	Accreditation agency management groups	4 (47)
	Professional colleges and associations	6 (38)
	Government health-care agency representatives	9 (35)
	Accreditation agency surveyors/assessors	4 (18)
	Health-care consumers	1 (8)
	Totals	34 (197)

This organization, with bodies in each state and territory in Australia, undertakes national policy and advocacy from the perspective of older people as citizens and consumers. Group interviews were preferred for their ability to elicit communication between participants, which helped generate comparative as well as individual perspectives.[26] Only where potential participants could not attend group sessions were individual interviews presented as an option. Interviews lasted between 30 and 90 min, were digitally recorded and professionally transcribed. In total, there were 34 interviews (31 groups and three individual) with 197 participants, who collectively represented the diversity of stakeholders influencing the development and implementation of the reform.

Transcripts were thematically analysed[21] using textual grouping software, NVivo v.9,[25] to facilitate systematic classification of data. Similarly, reports and observation notes were subject to analysis using the three predetermined study issues to guide data classification. As the aim was to uncover participants' views and ideas, there were no size limits placed on segments of coded text.[21] Systematic coding of data was completed by one researcher, and the research team collaboratively reviewed the coding and iteratively developed the findings through on-going discussions.

Results

The results are structured according to the three aims of the study. The three sections report stakeholder perceptions about how the Scheme developed, expected benefits, and key implementation challenges and facilitators of the Scheme.

Stakeholder perceptions about how the Scheme developed

Reform of accreditation commenced a decade before implementation. Three interlinked phases were involved: policy agenda setting, stakeholder consultation and impact assessment, and policy finalization and introduction.

Policy agenda setting: 2000–2006

The former Australian Council for Safety and Quality in Health Care initiated a detailed review of standards setting and accreditation in 2000.[27–29] On the basis of the findings, the Australian Health Minister's Council established a *Review of Future Governance Arrangements for Safety and Quality* in 2004,[30] which proposed designing a new accreditation system capable of ensuring on-going, national replication of evidence-based processes associated with safety and quality.[11] The ACSQHC was established in 2006 and was charged with coordinating this reform, with three specific objectives: outline potential evidence-based improvements to existing systems; develop a national set of accreditation standards against which health services could be assessed; and provide recommendations to guide implementation processes.[31]

Stakeholder consultation and impact assessment: 2006–2011

Between 2006 and 2011, the ACSQHC engaged in extensive, nationwide consultation of healthcare stakeholder groups and individuals to gain input to the review, including Federal and State Government regulators, accreditation agencies, insurers, health services, research experts and consumers.[32] Diverse consultation mechanisms were employed,[31,32] including the development of technical and expert working groups; the release of public consultation papers outlining proposed reforms; piloting of the proposed scheme; and on-going reporting to Australian Health Ministers. Study participants indicated that extensive consultation was necessary due to the critical or cynical perceptions of the reform measures initially held by many prominent accreditation stakeholders and State Government health departments.

> The Commission is an extension of the executive of government and it's very dangerous because they are funded by government. And if the standards start getting diluted, watered down there will be healthcare implications. (Accreditation agency representative, Focus group #26)

In total, the ACSQHC arranged 227 separate consultation activities involving over 1000 stakeholders spanning the breadth of the Australian health system.[32] When asked to assess the Scheme's development, participants emphasized the influential role of the ACSQHC in effectively coordinating the reform by aligning stakeholder interests.

> It's probably been one of the best processes that I've been involved with, in terms of real consultation... just the constant feedback of opinions and the clarification... All of the people [ACSQHC] have been extremely respectful of difference, because if you're talking about a regulatory environment, we've got every State and Territory who organises everything in such a disparate way, and they've all got their focus areas, but just the amount of respect that's been shown, but still coming to some decision about things and trying to push a national agenda... I thought it was impressive. (State Government health department representative, Focus group #19)

In addition to consultation activities, a regulatory impact statement was produced by the ACSQHC to outline the Scheme's likely financial consequences.[31] The methodology used was based on programme budgeting and marginal analysis guidelines.[33] The report concluded that an initial investment of approximately AU$1 million was required by accreditation agencies to initialize the Scheme.[31] Financial impacts on government regulators, health services and other stakeholders were not specified.

Policy finalization and initial implementation: 2011–2013

The NSQHS Standards were approved by the Australian Health Ministers' Council in September 2011. In the ensuing year, regulatory mechanisms and surveying processes necessary to effectively apply the Standards were finalized. The Private Hospital Sector Committee, ACSQHC Board, Inter-Jurisdictional Committee, Regulators Working Group and Accrediting Agencies Working Group were key forums through which operational details were negotiated and decided. The Scheme was introduced on 1 January 2013 and is now compulsory for all public and private hospitals and day-procedure centres. The ACSQHC continues to undertake wide-ranging activities, including ongoing consultation with health services, to facilitate effective implementation of the Scheme. A revision of the NSQHS Standards is scheduled for 2015 to assess their continued relevance, explanation and application.[32]

Expected benefits

Participants expected the Scheme to enhance patient-centred care at each level of the health system, that is, to promote the engagement of clinicians in patient quality improvement activities, assist health services to improve systems used to identify and respond to patient safety problems and implement standardization, integration and transparency for the health system through a national safety and quality framework.

The NSQHS Standards are evidence-based and largely clinically focused, which was considered crucial for potentially increasing the engagement of health professionals and board members in safety and quality improvement activities. Additionally, at the health services level, the NSQHS Standards provide an explicit framework that directs organizations to improve their systems for understanding and addressing patient safety and quality issues. Institutions can use the NSQHS Standards to engage health-care professionals and coordinate their actions in improvement activities directed at high-quality patient care.

> If you have a look at the 10 National Standards, at one end they've got governance. At the other end, they've got the management of pressure ulcers and you think, 'well, that seems really weird.' But we know pressure ulceration is managed badly, okay. We know governance is very, very variable. So by putting some National Standards together, we say, 'well, we're going to lift those two things. (Quality improvement agency representative, Focus group #13)

At the health system level, participants proposed that the NSQHS Standards provided, for the first time, a clearly evidenced-based, coherent and integrated national framework.

The Scheme separated and clarified responsibility for different actors for accreditation standards development, surveying processes and decisions, and regulation and policy matters. As a result, the Scheme standardizes expectations, integrates roles and responsibilities, and promotes transparency at all levels.

> I think people will be held accountable much more easily… a much clearer level of accountability across the system that didn't previously exist… it isn't just the hospital's fault or the CEO's fault or you can't just blame the accrediting agency because the system failed. You know, the regulator's got a role in this and they can't adjust it. So each party's role is much clearer… It's about making sure that the relationships and the framework gives everybody a buy in to having… an unambiguous role. (Senior manager, healthcare professional representative organisation, Interview #15)

Current and future implementation challenges

In addition to the significant potential benefits identified, participants noted challenges that could, or may already, be impeding the implementation of the Scheme. At the individual level, stakeholders emphasized the difficulty of developing and maintaining consistent expectations amongst frontline clinicians regarding the aims and requirements of the reform. Corroborating this assertion, participating stakeholders often voiced confusion concerning key aspects of the Scheme.

> I actually think it's a very confused area of policy making. And the classic for me is that it depends on whether it's driven by politicians, driven by the bureaucracy or driven by the industry. Driven by the bureaucracy, as we're seeing with the NSQHS Standards from the Commission, it's – the program, to me, has been developed without proper thought being given to what are the consequences of this program and how will that be managed? So now we've got a program that's been launched which has got potentially very significant political consequences and people are now not sure how that's going to be managed. (Accreditation agency management representative, Focus group #27)

At the health service level, an identified challenge was reliably assessing the compliance of individual institutions with clinical performance measures and their continuous quality improvement of organizational systems and processes. Several stakeholders argued that there is insufficient focus on promoting on-going improvements within the NSQHS Standards. Countering this view somewhat, other participants suggested that as has occurred in respect to other prominent Australian health-care accreditation programmes, future iterations are likely to shift greater emphasis towards this requirement. Also, concerns were raised by participants that focusing solely on the new standards would come at the expense of other organization process and initiatives.

> … the 10 National Standards is great, but I would hate to think that we lose sight of all the non-clinical stuff that actually supports the clinicians to do what they're doing. (Healthcare professional, Focus group #7)

In particular, two potential risks to the credibility of and satisfaction with the Scheme at the health system level were raised. That is, first, the application of the NSQHS Standards across settings and the second risk is the reliability of assessments by different accrediting agencies. The application of the NSQHS Standards across settings was discussed as a point of credibility. That the same expectations would be applied to different health services, in different settings, was considered vital to continued engagement with the Scheme. That the ACSQHC would continue to maintain strong expectations for high performance against the NSQHS Standards was yet to be tested. The issue was particularly stressed in regard to the NSQHS Standard focused on promoting consumer engagement in health care.

> … there are going to be a few shocks because where they [health services] meet accreditation easily now… they may not meet it quite so easily with the Standards because the Standards are much more prescriptive. (Government policy representative, Focus group #17)

Similarly, satisfaction with the Scheme was perceived to rest upon the reliability of assessments, within and across accrediting agencies. The need for mechanisms to ensure consistent surveying methods and outcomes across diverse accreditation agencies was discussed. Participants maintained that inconsistency, that is, low inter-rater reliability,[34] was highly likely, and this could undermine the Scheme's credibility. There was debate about whether the government agencies had taken sufficient actions to ensure survey reliability. It was noted that the regulator of the system, the ACSQHC, was aware of, and was developing training activities for accreditation agencies to address, this issue. Some participants perceived the Scheme to be flawed as these activities were not in place prior to commencing the use of the NSQHS Standards.

> One of the challenges we talked about earlier was the limited, if any, training that current surveyors have had in relation to surveying against the [NSQHS) Standards. (Healthcare professional representative organisation, Focus group #16)

Strategies to facilitate implementation

Four strategies to facilitate implementation, to reinforce the potential benefits and to overcome the substantial challenges facing the Scheme emerged and are presented in Fig. 1 and discussed below. Participant's explanations revealed them to be inter-related and to inform one another.

Regular and diverse ACSQHC consultation activities were seen to facilitate implementation by providing a platform for knowledge transfer, encouraging widespread stakeholder engagement. Aligned to this issue was the necessity for the forthcoming governmental educative activities and materials to assist health services' understanding of the Scheme. Participants emphasized the importance of disseminating educative materials that are both informative and easily accessible to different stakeholders.

> The devil is in the detail and it [effective implementation] will depend on how clear the guides that support the Standards are, and the decision-making tools which decide whether or not you meet that Standard. (Healthcare professional, Focus group #2)

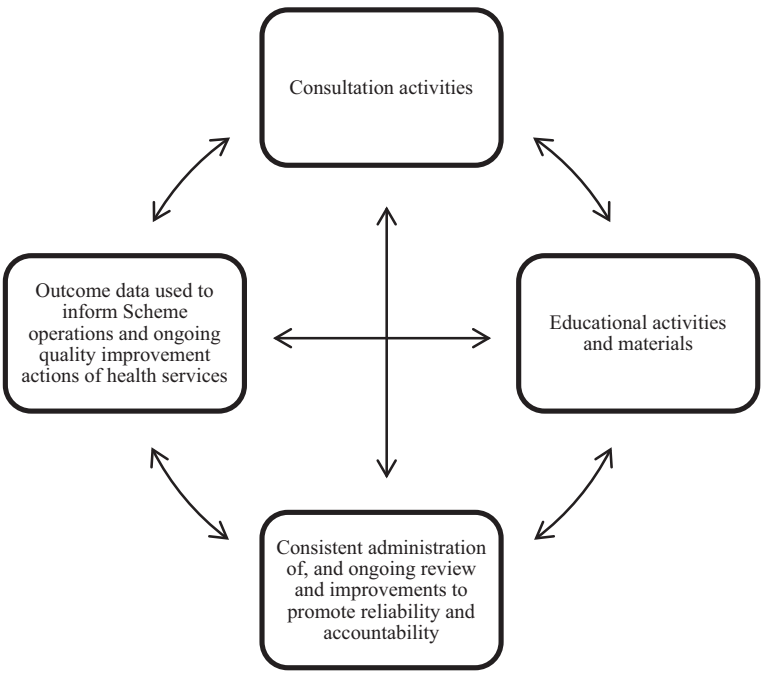

Figure 1 Strategies facilitating implementation.

The consistent administration of, on-going review, and improvements to the Scheme were together identified as a further implementation strategy. The transparent and critical evaluation of accreditation agencies' survey methods and decisions was commonly argued as necessary to justify and maintain the Scheme's ethos of promoting greater regulatory accountability. The Regulators Working Group and Accrediting Agencies Working Group were seen to have important roles in this regard. Furthermore, participants considered it necessary for accreditation outcome data, indicating health service deficiencies and malpractices, to be systematically processed by regulators, with consequences enforced. To achieve this, the importance of leveraging government legislative powers, at state and federal levels, was emphasized.

Discussion

The AHSSQA Scheme is characteristic of the increasing global trend towards government-led accreditation reforms aiming to address consumer and health stakeholders' demands for improved safety and quality in health care.[8] Likely benefits arising from the Scheme are anticipated to be realized at multiple levels of the Australian health system, from potentially increasing the involvement of professionals in quality improvement activities to providing a nationally consistent framework specifying safety and quality measures and requirements. The perceived benefits stakeholders identified illustrate the potential value of such reforms and the key role of accreditation programmes in supporting improved quality and safety in health care. This is the positive view of stakeholders embedded within a system that has a long history with accreditation in health care. However, the Scheme will be enacted within the complex adaptive system of health care,[35] dynamically modified in response to multifarious and interlinked institutions, groups and structural arrangements that can hinder or facilitate implementation. International experience shows the inherent complexity of health care, regardless of country, is an impediment to implementation of systems-level reforms.[4] Study participants noted that this complexity may prevent the Scheme from achieving its goals.

To respond to this challenging environment, the responsible agency for implementing the Scheme undertook extensive consultation activities. The findings indicate that their aim was to determine appropriate methods of utilizing existing government legislative powers to support the reform, align the views and actions of diverse groups and foster distributed leadership over the reform.[36] The perceived importance of these activities for maximizing the chance of achieving positive outcomes reinforces the fundamental role of continued stakeholder engagement as a necessary facilitator of national accreditation reform. The importance of effective stakeholder engagement has also been identified in relation to other systems-level health-care reforms internationally.[37–40]

The study highlights three elements of effective stakeholder engagement that can facilitate the development and implementation of national accreditation reforms. First, the establishment of concrete mechanisms, such as government-convened committees, which enable regular, open and transparent communication flows between different stakeholders. Second, the credibility of government agencies disseminating reform-related information is paramount and can be promoted by authentic consultation practices. Third, while the aims and requirements of reforms should be conceptually unified, the formats and language used to disseminate policy information should be strategically designed to appeal to the varied normative practices of different stakeholders. Targeting of these three elements may allow agencies responsible for implementing national accreditation reforms to harness stakeholder engagement more effectively as a critical facilitator.

While such activities characterized the design and implementation of the Scheme, there is no guarantee that it will realize the sum of its intended benefits. This view was stressed by a limited number of participants who remained sceptical of its value. National accreditation programmes in other settings have produced

variable results,[10,14,16] and standards-based measurement and reporting systems are prone to unanticipated consequences.[41] To empirically evaluate the health system and patient outcomes resulting from the Scheme, high-quality formative and summative evaluation studies are necessary. Longitudinal study designs should be able to detect effects at multiple health system levels, for example individual, organizational and system changes over time, to address issues of sustainability.

Regarding study limitations, despite the large numbers of participants, the interview samples were not randomized or statistically representative. Furthermore, while rigorous methods were used to codify the views of a diverse, nationwide range of health-care stakeholders and professionals, these remain participants' perceptions rather than objective information regarding the AHSSQA Scheme's development and implementation. Mitigating these limitations, the triangulated design helped illuminate multiple perspectives and converged on a common view.

Conclusions

Governments are increasingly undertaking national accreditation reforms to improve the safety and quality of health care. While engendering significant stakeholder support, diverse and complex implementation challenges must be overcome to obtain the considerable potential benefits. Drawing on Australia's recent experience in developing and implementing the AHSSQA Scheme, important facilitation mechanisms identified in this study, including key components of effective stakeholder engagement, can inform strategic planning for similar reforms internationally.

Acknowledgements

None.

Funding

The research was supported under the Australian Research Council's Linkage Projects funding scheme (project number LP100200586), and a National Health and Medical Research Council Program Grant (project number 568612).

Competing interests

Margaret Banks is a Senior Program Director at the Australian Commission on Safety and Quality in Health Care, and is centrally involved in the implementation of the Australian Health Service Safety and Quality Accreditation Scheme. The other authors declare that they have no competing interests.

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