Report prepared for the Ministry of Health

Governance of endoscopy quality and related initiatives - report for stakeholder feedback

Anna Livesey, Jo Esplin

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sapere research group

About Sapere Research Group Limited

Sapere Research Group is one of the largest expert consulting firms in Australasia and a leader in provision of independent economic, forensic accounting and public policy services. Sapere provides independent expert testimony, strategic advisory services, data analytics and other advice to Australasia's private sector corporate clients, major law firms, government agencies, and regulatory bodies.

Wellington	Auckland 1	Auckland 2
Level 9, 1 Willeston St PO Box 587 Wellington 6140 Ph: +64 4 915 7590 Fax: +64 4 915 7596	Level 17, 3-5 Albert St PO Box 2475 Auckland 1140 Ph: +64 9 913 6240 Fax: +64 9 913 6241	Level 1, 441 Queen St PO Box 2475 Auckland 1140 Ph: +64 9 354 4388
Sydney	**Canberra**	**Melbourne**
Level 14, 68 Pitt St GPO Box 220 NSW 2001 Ph: +61 2 9234 0200 Fax: +61 2 9234 0201	Unit 3, 97 Northbourne Ave Turner ACT 2612 GPO Box 252 Canberra City, ACT 2601 Ph: +61 2 6267 2700 Fax: +61 2 6267 2710	Level 2, 65 Southbank Boulevard GPO Box 3179 Melbourne, VIC 3001 Ph: +61 3 9626 4333 Fax: +61 3 9626 4231

For information on this report please contact:

Name:	Anna Livesey
Telephone:	09 909 5811
Mobile:	027 7284018
Email:	alivesey@srgexpert.com

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Glossary

Accreditation: for the purposes of this report, "accreditation" refers to a process by which endoscopy units are externally assessed and accredited as having met a defined set of standards. In this report we generally refer to "unit-level accreditation", to avoid confusion with credentialing.

Credentialing: credentialing is a process used by health and disability service providers to assign specific clinical responsibility to health practitioners on the basis of their education and training, qualifications, experience and fitness to practice within a defined context. Credentialing is a responsibility delegated to professional peer groups in co-operation with professional bodies (e.g. Colleges)[1].

Governance: governance is to do with setting a strategic direction for an entity, project or programme, and includes tasks such as establishing strategies, policies and procedures, and then monitoring results to ensure that implementation is effective and the intended outcomes are being achieved.

National Endoscopy Quality Improvement Programme (NEQIP): a programme established in 2012 to improve the quality of endoscopy services in New Zealand, including by rolling out the New Zealand Global Rating Scale (NZGRS).

New Zealand Global Rating Scale: a web-based self-assessment tool that provides a quality framework for service improvement, based on a similar tool in use in the UK.

Quality Assurance: is "a process that ensures a pre-determined set of standards is achieved"[2]. In the context of the NZGRS and endoscopy in New Zealand, accreditation is the proposed basis of the quality assurance approach.

Quality Improvement: quality improvement is "a process based upon cycles of measuring, planning, implementing and further measuring"[3], focussed on continually improving quality, rather than assessing whether a specific standard has been met at a given point in time. To date, the work undertaken by NEQIP and DHBs implementing the NZGRS has been focused on quality improvement rather than quality assurance.

[1] Ministry of Health, *Credentialing Framework for New Zealand Health Professionals*, 2010, p.2.

[2] Roland Valori, Quality Improvements in Endoscopy in England, *Techniques in Gastrointestinal Endoscopy* (2012), 14, p. 66.

[3] Ibid.

1. Introduction

1.1 About the project

The Ministry of Health commissioned Sapere Research Group to provide independent advice on an appropriate national governance structure for endoscopy quality improvement and related initiatives. The brief was to consider the following functions and relationships, and how they might best be incorporated into a national framework:

- Leadership/governance.
- NZGRS.
- Unit-level accreditation.
- Training.
- Workforce (planning and capacity and demand).
- An advisory function.

We also considered required revenue streams and possible funding options.

In developing this report, we have undertaken a first round of engagement with stakeholders, held discussions with the Ministry, and reviewed relevant documents.

1.2 About this report

This report describes options for a national governance structure for endoscopy quality improvement and related initiatives. The purpose of this report is for stakeholders to consider the options and provide comment on what the preferred option should be. This report builds on the work on a national governance framework previously undertaken by the National Endoscopy Quality Improvement Programme (NEQIP).

The body of this report lays out the proposed structure and discusses some of the requirements for effective quality improvement and quality assurance (accreditation) programmes. We are seeking your comment on these aspects. The appendices supply supporting information, including a summary of findings from the initial round of stakeholder engagement.

1.3 The Ministry's position

The Ministry is committed to ensuring that all endoscopy services, screening and symptomatic, provide the same high quality service to all consumers. The Ministry sees NZGRS and a unit-level accreditation programme as a key part of ensuring quality for endoscopy in New Zealand and supports a national quality programme. The Ministry is also supportive of related activities such as initiatives to standardise endoscopy training and improve unit productivity.

From our discussions with the Ministry, we understand that in principle the Ministry is willing to consider funding:

- A secretariat to support a National Endoscopy Leadership Group.
- A NZGRS and accreditation governance group and associated secretariat.
- An on-going quality improvement programme.
- An accreditation programme, when this is appropriate and agreed.

Part of the purpose of this exercise is to clearly establish the sector's preferred option for on-going governance, leadership and funding of the various workstreams related to endoscopy quality. Clarity regarding the sector's preference will support the Ministry's ability to make the case for any central funding that may be required to support this work.

1.4 How to have your say

There will be an opportunity to participate in a sector workshop to be held in Wellington on 10th June 2015. This workshop will present the proposed option and will record feedback and suggestions for any change. If you cannot attend the workshop, you can provide written feedback to Sapere instead, using the template provided at the back of this report. We will accept written feedback until 24th June 2015 (two weeks after the workshop). Please send any written feedback to Anna Livesey on alivesey@srgexpert.com.

If you wish to attend the workshop and have not received an invitation, please contact sanderson@srgexpert.com for details.

Following this round of feedback, Sapere will prepare an independent recommendations report for the Ministry.

2. Proposed national structure

2.1 Context for designing a national structure

This section lays out the key issues we took into account in designing the proposed structure.

2.1.1 Leadership across the endoscopy community

Our initial stakeholder engagement showed a clear desire for leadership and co-ordination across the sector. This is reflected in some of the roles that NEQIP initially identified for a national governance group. These included: [4]

- Provide a single central resource for New Zealand Endoscopy Services.
- Promote a maintenance and continuous education of high standards of GI endoscopy within the profession.
- Provide leadership for the use of the endoscopy quality improvement methodology.
- Provide advice on innovations in service provisions (e.g., new innovations, new procedures and new roles).
- Facilitate relationships and networks between endoscopy units and other relevant professional bodies and organisations.
- Coordinate dynamic capacity and demand planning on a national scale.

This type of networking, influencing and advising is a valuable role, especially in a small but geographically spread community like the endoscopy community. However, the roles described above are focussed on leadership, rather than governance. Providing advice, resources, leadership and networking and coordination does not come with the level of accountability and responsibility implied in "governance".

To clarify the difference between leadership and governance, a "leadership group" leads through influence and education, and is able to initiate projects supported by its members, but does not have any formal responsibility for setting policies or directions or overseeing the management of specified activities. By contrast, a "governance group" has formal responsibilities to set policies and directions, and oversee the implementation of specific activities.

2.1.2 Governance for NZGRS and accreditation programme

If NZGRS and progress towards accreditation are to continue, there will need to be a governance entity that is responsible for these programmes. This entity will be responsible for setting the strategic direction for NZGRS and unit-level accreditation, and

[4] NEQIP, *Draft Governance Framework*, 12/3/2014, p.13-14.

the policies, procedures and processes through which that strategic direction is to be implemented.

To be successful, such an entity will need strong sector and clinical input, both to ensure that the standards and strategies are appropriate and effective, and to gain sector buy-in to the programme.

2.1.3 Recognition of the relationship between the elements of quality

Quality elements across the system are linked. Unit, individual staff, and training quality elements are clearly linked. A unit cannot provide a high-quality service unless it has well-trained staff. In turn, it is difficult for even the best trained, most up-to-date staff to provide a good service if the facilities and systems are inadequate. The diagram below shows the inter-relation between unit, individual, and training quality.

Figure 1 Relationship between unit quality, individual quality and training quality.

Source: NEQIP, presentation prepared 13/11/14.

NZGRS reflects this link by including workforce and training as two of the four quality domains, as shown in the table below.

Table 1 Summary of NZGRS – four quality domains

1. Clinical Quality	2. Quality of the Patient Experience
1. Information/consent	1. Equality of access
2. Safety	2. Timeliness
3. Comfort	3. Choose and book
4. Quality	4. Privacy and dignity
5. Appropriateness	5. Aftercare
6. Results to referrer	6. Patient feedback

3. Workforce	4. Training
1. Skill mix review and recruitment	1. Environment and opportunity
2. Orientation and training	2. Endoscopy trainers
3. Assessment and appraisal	3. Assessment and appraisal
4. Staff are cared for	4. Equipment and materials
5. Staff are listened to	

Source: NEQIP, presentation prepared 13/11/14.

Given these links, the governance of training should ideally be linked to the governance of NZGRS and accreditation.

Further, workforce and capacity planning are also relevant to quality. Any screening programme will create additional demand for colonoscopy procedures which, if not properly planned for, could affect quality for screening and symptomatic services, including by increasing waiting times.

2.2 Objectives of a national quality structure

Given the issues in section 3.1, we propose the following objectives for a national quality structure for endoscopy. A national quality structure will:

- Oversee national quality standards (NZGRS).
- Ensure all units have access to assistance to meet quality standards through a quality improvement programme.
- Design and oversee a national accreditation system for all units.
- Provide leadership across the endoscopy community.
- Ensure clear links between the governance of the elements of endoscopy quality.

In our view, critical success factors for a national quality structure for endoscopy are:

- Support and involvement from the sector.
- A workable funding model.
- The ability to adapt over time, as the system matures and external factors change.

Feedback Question 1:

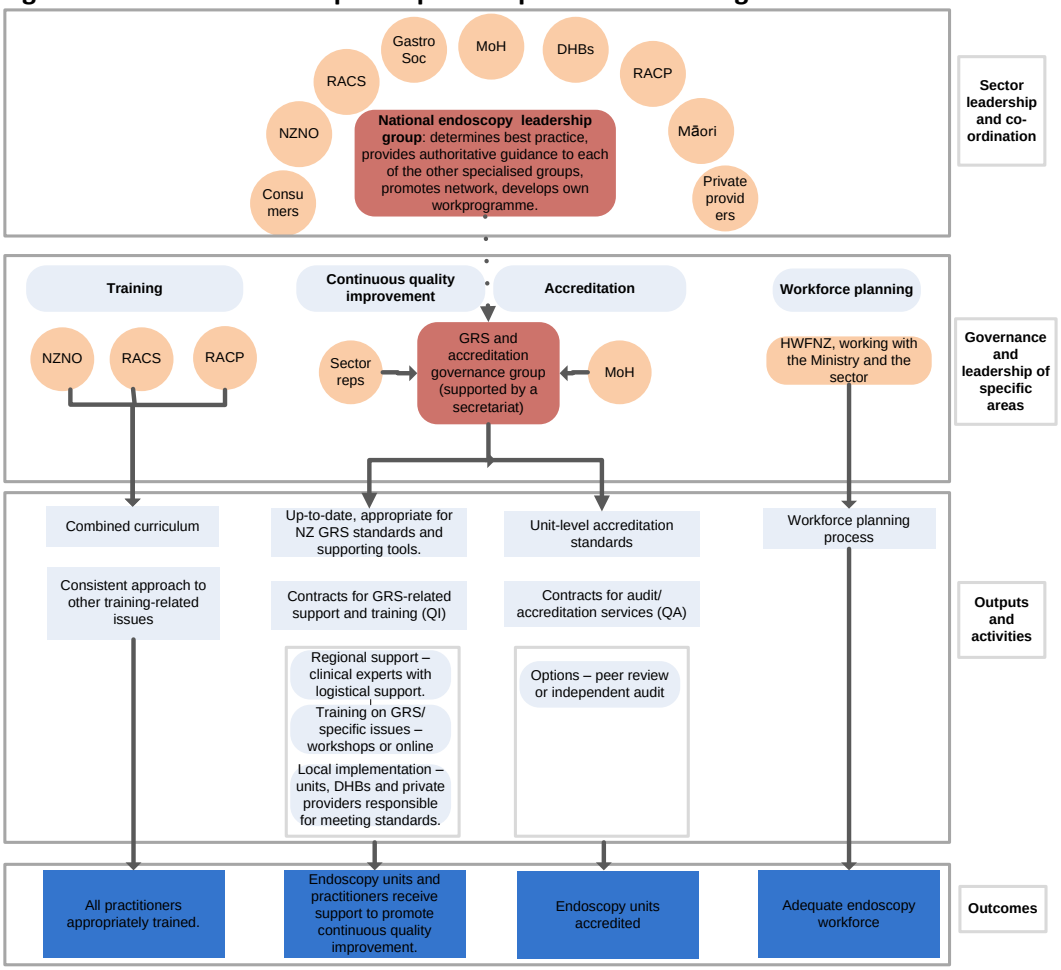
Do you agree with these objectives?

What would you change/suggest?

2.3 Proposed national structure

In this section, we propose a national structure for endoscopy quality, which includes the elements necessary to support NZGRS and accreditation, and a National Endoscopy Leadership Group. This is an initial recommendation, intended to be tested through further sector feedback.

Figure 2 National Leadership Group and separate but linked governance structures



Source: Sapere.

2.3.1 National Endoscopy Leadership Group

We propose a National Endoscopy Leadership Group (NELG), to provide leadership and advice across all endoscopy-related issues. The group would have a small (e.g. less than 1 FTE) secretariat. The NELG would have representatives from the sector, the Ministry and consumers as members, on a voluntary basis. It would be a forum for clinicians, management, consumers and others with an interest in endoscopy to raise issues, share best practice, advocate for change where required and provide a single voice on the needs and priorities for endoscopy in New Zealand.

This group could chose to pick up specific projects, such as researching and reporting on best practice innovations, or encouraging the use of a nationally consistent productivity tool. The group would need to agree how to resource these projects, for example by forming a working group, or by seeking project-specific funding, if there was a potential funder with an interest in a particular project.

Proposed membership and nomination process

We propose that the following organisations and interests should be represented on the NELG:

- Consumers.
- District Health Boards.
- Māori.
- Ministry of Health.
- New Zealand Nurses' Organisation.
- New Zealand Society of Gastroenterology.
- Private providers.
- Royal Australasian College of Physicians.
- Royal Australasian College of Surgeons.

The organisations listed above would be able to nominate one or two members to the NELG. District Health Boards and private providers would need to organise to nominate one or two representatives. The Ministry would facilitate the nomination of consumer and Māori representatives.

Terms of reference and work programme

We propose that the NELG would establish its own terms of reference, elect its own chair and develop its own work programme.

Feedback Question 2:

Do you support a National Endoscopy Leadership Group?

Would your organisation nominate a member for such a group?

Are there other organisations or interests that should be represented on this group?

How often should such a group meet?

2.3.2 Dedicated governance group for NZGRS and unit-level accreditation

Implementing NZGRS and unit-level accreditation requires three key elements to be in place:

- A governance group.
- A quality improvement (QI) programme.
- A quality assurance (QA) (accreditation) programme.

We discuss the governance group in this section. Considerations for the QI and QA programmes are included in section four.

Governance group

We propose that a governance group, supported by a small secretariat, be established to govern the NZGRS and unit-level accreditation. This group would be responsible for:

- Overseeing national quality standards (NZGRS), including reviewing them as required.
- Establishing the approach to a quality improvement programme that would to ensure all units have access to assistance to meet quality standards.
- Designing and overseeing a national accreditation system for all units, including making decisions on peer-review or independent audit model, any step-wise introduction of accreditation, frequency of accreditation, etc.
- Monitoring results from the QI and accreditation programmes (including anonymised DHB data and aggregated census data from NZGRS), and where necessary, reviewing the strategic direction.

These responsibilities would be formalised and agreed in terms of reference for the group.

This group would need to have a strong clinical and quality focus. Given that this group would have formal responsibilities, we recommend that members are paid for attendance. The group would nominate its own Chair.

Feedback Question 3:

Do you agree with a dedicated governance group for NZGRS and accreditation? Why/Why not?

If yes, which organisations or groups do you think need to be represented on the NZGRS and accreditation governance group?

Implementation options

The implementation options for a governance group and the associated quality improvement and accreditation programmes will depend on the funding option that is selected (funding options are discussed in the section 3).

If, following this round of feedback, a sector-led and sector-funded model is agreed, it will be up to the sector leader(s) to develop implementation options for a governance group and the associated programmes.

If Ministry funding is established as the most feasible option, the Ministry will need to seek funding, and, if and when funding is available, establish the appropriate contracting structure to ensure that the governance group is convened and supported, and that the quality improvement and quality assurance programmes are implemented.

2.3.3 Workforce development remains with existing organisations

Training

From our initial round of engagement, we found strong support for a more consistent approach to training for all endoscopists in New Zealand. Developing and implementing a more consistent approach will require the relevant professional organisations to work together. In the future, this may include developing some form of shared governance of training that goes beyond the existing conjoint committee process for recognising endoscopy experience.

However, we do not recommend attempting to bring the governance of training for endoscopists under the same governance structure as NZGRS and accreditation. While training is clearly linked to unit quality, this link can be maintained by ensuring that the bodies responsible for training are represented in the governance of NZGRS and accreditation. In addition, the National Endoscopy Leadership group will provide a forum for continued cooperation in the area of training.

Feedback Question 4:

Do you agree that the governance of training should continue to be undertaken by the existing professional organisations (i.e., the Colleges)?

Workforce planning

Workforce planning, in particular to meet the needs of a national screening programme, is an issue that was raised with us during our initial interviews. Health Workforce New Zealand is the appropriate mechanism through which workforce planning should be undertaken. This planning needs to be closely aligned with the Ministry's bowel cancer programme to ensure screening volumes and requirements are well understood. We did, however, receive feedback that Health Workforce New Zealand could communicate better with the sector to improve understanding of its work, and the outcomes it achieves.

A National Endoscopy Leadership Group, if established, could provide valuable input and advice to Health Workforce New Zealand on workforce planning.

Feedback Question 5:

Do you agree with the overall national structure outlined in this section and summarised in figure 2?

What would you change/suggest?

2.3.4 Any structure to be reviewed in three years

We recommend that any structure that is established is reviewed after three years how well it is meeting its objectives, whether those objectives are still valid and whether alternative ways of meeting the objectives may now be preferable.

3. Funding options

3.1 Three broad options

There are three broad options for funding the proposed national structure and associated QI and QA work:

1. Sector funding (primarily through payments from DHBs and private providers to participate in NZGRS and the associate QI and QA programmes); or
2. Central (Ministry) funding;
3. A mixed model, with Ministry funding supplemented with some sector contributions.

Note that any Ministry funding will be subject to the Ministry's ability to secure a budget for this work.

3.1.1 Amount of funding required

Our initial estimate, based on the current budget for NEQIP, is that funding of at least $500,000 per annum would be required to sustain a governance structure, quality improvement and quality assurance programme.

For context, if there were 40 participating units (all 32 public units and 8 private units), that would be an average of $12,500 per unit per year to sustain a totally sector-funded model (option 1). We note that this cost would be likely to be distributed so that units with a larger volume of procedures paid more, and units with a smaller volume of procedures paid less.

3.2 Option 1: Sector funding

In the UK, the GRS and associated quality improvement and accreditation programmes are funded through sector fees, charged on a per-unit basis. The advantage of a sector-funded model, as in the UK, is that would allow the sector to fully own the NZGRS and associated QI and QA activities.

However, there are a number of barriers to a sector-funded and sector-driven approach in New Zealand, at least in the short to medium term. In our initial engagement with the sector, we did not find strong support for a sector-funded model for endoscopy quality in the foreseeable future. Further, we did not find an organisation that was willing to take on ownership of the NZGRS and associated programmes, especially without a guaranteed funding source.

Sector-funded models can pose particular problems in a small country like New Zealand. A larger country like the UK, with over 400 units, has two advantages in establishing a sector-funded model:

a) The fixed costs of establishing and running a quality improvement and assurance programme can be spread over a much larger base of units, reducing the cost for everyone; and

b) The number of units means that there can be some churn – some units pulling out and others joining – without the viability of the programme overall being threatened.

In New Zealand, there are 32 public units and a number of private units. Given the smaller number of units, the programme is likely to be more expensive per unit in New Zealand than in the UK. This applies however the costs are distributed – i.e., through a 'per unit', or 'per procedure' or 'per head' of population-based fee.

Further, because of the smaller number of units, the programme would be vulnerable to fluctuations in participation. If several units or providers choose to stop participating (and therefore stop paying their fees), then the financial viability of the programme overall could be threatened.

For these reasons, we suggest that a sector-funded approach is not practical at this stage. However, we note that this report, and the sector feedback based on this report, is an opportunity to test this recommendation.

3.3 Option 2: Ministry Funding

Option two is for the Ministry to provide funding for the key elements of a national approach to endoscopy. From our discussions with the Ministry, we understand that in principle the Ministry is willing to consider funding[5]:

- A secretariat to support a National Endoscopy Leadership Group.
- A NZGRS and accreditation governance group and associated secretariat.
- An on-going quality improvement programme.
- An accreditation programme, when this is appropriate and agreed.

The Ministry would contract out all of these functions, to ensure a level of separation between the Ministry and the implementation of these functions. However, as a funder, the Ministry would require the usual level of accountability and oversight of public funds.

Advantages of a centrally-funded model include that units and providers do not face a cash-based incentive not to participate and that the programme can be sure of the level

[5] As noted previously, any such funding is subject to the Ministry securing appropriate budget.

of its funding for the length of the contracts. However there is, as with all central funding, the risk that priorities could change and contracts might not be reviewed.

We note that, under this model, participation by private providers would be encouraged, but would be on a user-pays basis for private units.

We suggest that a Ministry-funded model is the most practical option in the short to medium-term.

3.4 Option 3: Mixed funding model

Option three is for the Ministry to provide some funding, with sector contributions. For example, it would be in line with other audit and accreditation programmes for units to pay a fee for audit and accreditation. In the medium term, this seems a reasonable option. Providers' willingness to pay for audit and accreditation functions could be further explored once the proposed model for audit and accreditation has been agreed.

We note that the Ministry would be likely to continue to be the majority funder under a mixed model, and that the Ministry would therefore continue to require the usual level of accountability and oversight of public funds.

We suggest that the NZGRS and accreditation governance group investigate the option of sector fees as part of finalising the model for quality improvement and quality assurance activities.

Feedback Question 6:

Which funding model do you support at this stage and why?

4. Continuous quality improvement and accreditation

4.1 Purpose of this section

This section outlines high level requirements for quality improvement and quality assurance (accreditation) programmes. Note that decisions on the approach to quality improvement and quality assurance will be taken by the governance group established to oversee these functions, rather than as a direct result of this project. This section, and the feedback on it, will feed into the governance group's decision making on the approach and detail of these programmes.

4.2 Quality improvement and quality assurance

> *Quality is the cumulative results of the interactions of people, individuals, teams, organisations and systems. It can be defined as the degree to which the services for individuals and populations increase the likelihood of desired health outcomes.*[6]

In designing an approach to quality, it is important to recognise the two aspects of a quality system: continuous quality improvement, and quality assurance. *Continuous quality improvement* is "a process based upon cycles of measuring, planning, implementing and further measuring"[7]. To date, NEQIP has engaged in a quality improvement process with DHBs, based on using NZGRS to measure quality, plan improvements and then measure again. Q*uality assurance* is "a process that ensures a pre-determined set of standards is achieved"[8]. In the context of the NZGRS and endoscopy in New Zealand, accreditation is the proposed basis of the quality assurance approach.

The NZGRS can be the basis for both a quality improvement and quality assurance approach. In terms of quality improvement, assessment against NZGRS provides units with a measurement of their current state. The shared resources in the knowledge management system, and the expertise supplied by the NZGRS training and support staff provides the resources for units to plan and implement improvements.

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[6] National Screening Unit, *Improving Quality: A framework for Screening Programmes in New Zealand,* 2005, p.1.

[7] Roland Valori, "Quality Improvements in Endoscopy in England", *Techniques in Gastrointestinal Endoscopy* (2012), 14, p. 66.

[8] Ibid., p. 66.

Reassessment against NZGRS measures the improvement that has occurred, and highlights areas for further work.

In terms of quality assurance, NZGRS can be used as a basis for audit and accreditation, with units being required to meet pre-defined levels against NZGRS, and being audited to ensure that they have reached those levels before being accredited.

4.3 Requirements for a quality improvement programme

4.3.1 Quality improvement is an on-going process

As noted above, continuous quality improvement is based on upon cycles of measuring, planning, implementing and further measuring. For this cycle to happen successfully there needs to be:

- A measurement and benchmarking tool, to track progress and identify areas for improvement;
- Support and training in the use of the measurement tool;
- A process for planning what improvements to make and how;
- Adequate resources to implement the changes; and
- Reapplication of the measurement tool, to track progress and identify further areas for improvement.

As noted above, NZGRS provides a measurement and benchmarking tool for quality improvement in endoscopy units.

4.3.2 Quality improvement must be owned by the team and organisation providing the service

Improving quality is the responsibility of the team and the organisation providing the service. It is the team, supported by their organisation, which needs to measure quality and then plan and implement changes.

This aligns with DHBs' legislative obligation to monitor "the delivery and performance of services by it and by persons engaged by it to provide or arrange for the provision of services" (New Zealand Public Health and Disability Act 2000, s.23(1)(i)) (see appendix 3 for a more detailed discussion of DHBs' role in regard to quality).

4.3.3 But training and support from outside are helpful

A large part of NEQIP's role has been to provide training to units on how to use NZGRS, and then on-going support on how to improve their results. Stakeholders we spoke to who had experienced this training and support valued it.

We also spoke to the Joint Advisory Group in the UK (the group that developed NZGRS, and licences it to New Zealand) about this aspect of the NZGRS approach. JAG staff made the point that on-going quality improvement, with support for units from appropriately qualified and experienced clinical staff, is critical to the success of a NZGRS-based approach.

An on-going training and support function would be likely to include site visits to units, assistance in assessing NZGRS results and planning for changes, maintaining a knowledge management system and initiatives such as regional workshops on specific topics. Our view, based on stakeholder feedback, is that such a function is an integral part of the NZGRS approach.

4.3.4 Data confidentiality is important for quality improvement

A quality improvement programme is based on the premise that the assessment of the current state will be as open as possible. For this reason, it is important that the data on individual unit performance is confidential between the provider and the quality improvement team, rather than being publically available or shared with funders.

The effectiveness of the quality improvement programme can be monitored through anonymised individual unit results and through aggregate data, such as that currently presented in the NEQIP census reports.

4.3.5 The quality improvement programme should be offered to all endoscopy units in New Zealand

At present, NEQIP provides NZGRS only to endoscopy units in DHBs. In the future, the quality improvement programme should be available to public and private units. We expect that, whatever funding model is established, private units would be required to pay a fee to cover the costs of their participation in the quality improvement programme.

Feedback Question 7:

Do you agree with the high level description of a quality improvement programme?

What changes or suggestions do you have?

4.4 Requirements for a quality assurance/accreditation programme

4.4.1 Quality assurance needs to be independent, robust and transparent

The purpose of a quality assurance programme is to provide assurance that a pre-determined set of standards has been achieved. A robust quality assurance programme needs:

- **A clear set of standards against which units are assessed.** NZGRS could provide the basis for such a set of standards.
- **Independent and impartial assessors.** Assessors should be clearly independent of the unit which they are assessing, of the funder (i.e., the Ministry) and of any quality improvement programme. This will prevent any perceived or real conflicts of interest.
- **Appropriately skilled assessors.** This is likely to mean teams with a mix of general health audit expertise and endoscopy-specific clinical expertise.
- **A consistent and reliable system of assessment and reporting** to provide assurance that everyone has been treated the same.
- **Transparency about results**. Audited quality assurance results should be publically available, so that funders, consumers and the community are aware of which units are accredited and which are not. (This is in contrast to on-going quality improvement, where the data is self-reported and should be confidential between the unit and quality improvement team.)

4.4.2 It may be helpful to introduce a two-step process

In the UK, the GRS accreditation process can have three outcomes: pass, deferred or fail. A unit that is "deferred" has some specific areas it needs to improve on, and will be reassessed within six months.[9]

A similar approach could be used in New Zealand, with units initially achieving a pass, a provisional pass or a fail, and units with a provisional pass being re-assessed within a short timeframe, say within 12 months.

[9] Roland Valori, "Quality Improvements in Endoscopy in England", *Techniques in Gastrointestinal Endoscopy* (2012), 14, p. 68.

4.4.3 Any national screening programme is likely to require participating units to be accredited

We understand from the Ministry that it is likely to require units that participate in any national screening programme to be accredited. We note that NZGRS does not provide a complete framework for ensuring screening quality and would need to be supplemented by screening specific standards, and by standards for other parts of the screening pathway.

At this stage, we understand that the Ministry is not contemplating any legislative change that would make accreditation compulsory for all endoscopy units. Non-screening units would be incentivised to participate through the proven benefits of quality improvement for patients and staff, through the fact that accreditation status (or the lack of) would be public.

Feedback Question 8:

Do you agree with the high level description of a quality assurance programme?

What changes or suggestions do you have?

4.5 Need for separation between QI and QA

In our view, it is important that there is separation between the quality improvement and quality assurance programmes. This is for two key reasons:

- To ensure independence between the people who are assisting teams and units to improve, and the people who are assessing the standard that the units have achieved; and
- To ensure that data captured for quality improvement purposes is kept confidential between the provider and the quality improvement team, and is not shared with individuals involved in the quality assurance, or with funders or the public.

Feedback Question 9:

Do you agree that the QI and QA programmes should be separate? Why or why not?

Appendix 1: Background to this project

NEQIP established to lift endoscopy quality

In November 2012, the Ministry of Health ("the Ministry") established the National Endoscopy Quality Improvement Programme (NEQIP). NEQIP is a time-limited change-management programme intended to improve the quality of endoscopy services across New Zealand, due to end in August 2015. The need for improvement in quality for endoscopy services was driven by the possibility of a national bowel screening roll-out.

The NZ Global Rating Scale

NEQIP's key tool for improving endoscopy is the New Zealand Global Rating Scale (NZGRS), a web based quality improvement tool that allows endoscopy units to self-assess against a set of standards. The NZGRS measures 21 patient-centred items and compares them to agreed standards. These items are divided into four main domains:

- **Clinical Quality** – covers appropriateness, consent process, safety, comfort, quality of procedure and timely communication of results.
- **Quality of Patient Experience** – covers equality of access and equity of provision, timeliness, booking and choice, privacy and dignity, aftercare and the ability to provide feedback.
- **Workforce** – includes skill mix review and recruitment, orientation and training, assessment and appraisal, staff are cared for, and staff are listened to.
- **Training** – covers environment and training opportunities, endoscopy trainers, assessment and appraisal and equipment and educational material.

The NZGRS has now been rolled out to all District Health Boards (DHBs) as a voluntary tool.

NEQIP's other workstreams

NEQIP has also been involved in other areas related to endoscopy, specifically: capacity planning; workforce development; and developing a draft national governance model.

Under the capacity planning workstream, NEQIP has provided endoscopy units with a productivity tool and a capacity and demand planning tool, and provided data to the Ministry. Under the workforce development workstream, NEQIP has supported the development of an Endoscopy Knowledge and Skills Framework for nurses and developed a draft curriculum for endoscopist training for review by the Royal Australasian College of Physicians (RACP) and the Royal Australasian College of Surgeons (RACS).

Under the governance workstream, NEQIP has drafted a proposed National Governance Framework for endoscopy services in New Zealand.

Appendix 2: Summary of initial stakeholder feedback

Thirty two stakeholder interviews were undertaken between January and March, 2015. We also spoke with the Ministry of Health's bowel cancer team, NEQIP staff and the Regional Cancer Network managers. Stakeholders were selected by the Ministry and NEQIP. Interviews were undertaken in a mixture of face-to-face and telephone interviews, individually, or in small groups. This section summarises the analysis of the stakeholder interviews. Our initial findings, along with additional research and liaison with the Ministry and other key stakeholders, have informed this report.

Key issues identified

Overall, stakeholders we interviewed consider there is a need for an on-going quality improvement programme for endoscopy in New Zealand. This is particularly the case in light of the additional demands that will be placed on the sector by the roll-out of a national bowel screening programme.

Support for NZGRS and accreditation – with central funding and support

Interviewees support the NZGRS and developing an endoscopy unit-level accreditation scheme based on NZGRS. Stakeholders supported unit-level accreditation for three main reasons. Because accreditation provides:

1. An on-going incentive for the focus on quality to continue;
2. Leverage and an objective standard to help in making the case for necessary facility upgrades or other improvements; and
3. Transparency for the staff and the public about the quality of service provided by endoscopy units.

The broad sense from the sector was that they believe that NZGRS and unit-level accreditation would need to be centrally funded, with incentives for on-going participation, in order to be successful. The view from the sector was that providers were unlikely to agree to bear the cost of an endoscopy quality programme.

NZGRS and accreditation will support a bowel screening programme

There is an opportunity to use the foundation laid down by the NZGRS as the basis for developing standards for endoscopy units involved in the bowel screening programme, by, for example, requiring that all screening units reach a certain level on each of the NZGRS measures.

Currently no clear sector leader for an NZGRS and accreditation programme

An important part of this project is to understand whether there is any appetite from a player or players in the sector in New Zealand to take on a lead role for the NZGRS and associated programmes.

In the United Kingdom, the GRS quality improvement programme, and the associated accreditation programme are run by the Joint Advisory Group on GI Endoscopy (JAG). This group was set up under the auspices of the Academy of Medical Royal Colleges and is hosted by the Royal College of Physicians.

During our initial stakeholder engagement, no entity indicated willingness to commit to taking on the leadership of an NZGRS and accreditation programme at this stage in its development.

Opportunity to standardise and improve training

There is broad agreement that training for endoscopists – whether they be surgeons, physicians, or, in the future, nurses – needs to be further standardised. There is a conjoint committee ("The New Zealand Conjoint Committee for Recognition of Training in Gastrointestinal Endoscopy") run by the two Colleges. This committee recognises individuals who have completed the training requirements set out by the conjoint committee. However, there is no shared curriculum, and we understand that some providers do not require that people practicing endoscopy have been accredited by the conjoint committee.

As noted above, the two Colleges see setting training requirements and recognition of training as part of their core business. The relevant nurses' organisations, the Nursing Council and the New Zealand Nurses Organisation, likewise consider that setting training requirements and recognising the training of their members is core business for them.

Concern about workforce and capacity planning

There is general concern about workforce and capacity planning, in particular because of the increased demands the bowel screening programme will place on endoscopy services. There is an opportunity for Health Workforce New Zealand to communicate more clearly to the sector about its activity in regard to endoscopy workforce planning.

There is also an opportunity for the sector to continue to work together on projects in this area such as, for example, using a standard productivity assessment tool, and sharing productivity and throughput data to assist with capacity planning.

Desire for leadership and co-ordination

Many of our interviewees commented that the endoscopy community would benefit from some overall leadership and coordination. There was initial support for a group that could provide ongoing advice on each of the areas such as accreditation, quality, standards, training, and workforce volumes and to take the lead on specific projects

such as implementing a national approach to measuring and reporting on endoscopy unit productivity.

Appendix 3: Existing quality and credentialing processes

Links between existing quality and credentialing processes and NZGRS and unit-level accreditation

Investigating how existing quality and credentialing processes in the health sector function, and where there are strengths or weaknesses is outside the scope of this project. However, this appendix outlines the existing processes and notes how they differ from NZGRS and unit-level accreditation.

DHB quality systems

Each District Health Board is responsible for monitoring "the delivery and performance of services by it and by persons engaged by it to provide or arrange for the provision of services" (New Zealand Public Health and Disability Act 2000, s.23(1)(i)). As part of fulfilling this responsibility, each DHB has a Quality Unit which manages risk and quality across the DHB and in associated entities such as Primary Health Organisations. We understand that these quality units set their own focuses, and do not assess specific services or units against nationally consistent quality standards, at least not for all services. There are national quality and safety markers, which are reported on by the Health Quality and Safety Commission. These markers cover four key areas – falls, health-care associated infections, peri-operative harm and medication safety – but are not a set of detailed quality standards for any given service or unit.

The Ministry certifies DHBs on a regular basis, to ensure that they provide safe, appropriate care for patients, and meet the standards set out in the Health and Disability Services (Safety) Act 2001.[10] DHBs are audited against six main standards, which cover: consumer rights; organisational management; patient care; the physical environment; infection prevention and control; and the management of restraint.[11] This certification provides assurance over the DHBs overall level of service and systems, but does not assess specific services or units against comprehensive quality standards like the NZGRS.

Credentialing individual practitioners

DHBs are also required to credential their senior medical and nursing staff. The Ministry's 2010 *Credentialing Framework for New Zealand Health Professionals* defines credentialing as:

[10] http://www.health.govt.nz/new-zealand-health-system/my-dhb/auckland-dhb/auckland-health-quality-and-safety, accessed on 25 March 2015.

[11] http://www.health.govt.nz/new-zealand-health-system/my-dhb/auckland-dhb/auckland-health-quality-and-safety, accessed on 25 March 2015.

> "a process used by health and disability service providers to assign specific clinical responsibilities to health practitioners on the basis of their education and training, qualifications, experience and fitness to practice within a defined context"[12].

The DHB credentialing process will consist of some way of both checking that practitioners have an up-to-date Annual Practicing Certificate, issued by their relevant professional body, and a peer review process led by DHB staff, to assess their competence to practice within their defined scope of practice.

The Annual Practicing Certificates are issued by responsible authorities as defined by the Health Practitioners Competence Assurance Act (HPCA) 2003. For surgeons and physicians, the responsible authority is the Medical Council. For nurses, it is the Nursing Council. These annual practicing certificates provided by the responsible authorities are underpinned by standards and/or defined levels of competence specified by professional colleges (such as the RACS and the RACP) and/or by specialist societies, (such as the New Zealand Society of Gastroenterology).

These processes ensure that individual practitioners are qualified and competent to undertake the work they do in DHBs. However, they do not assess the full quality performance of a given unit across domains such as consumer comfort, operational efficiency or waitlist management, as NZGRS does.

Health Quality and Safety Commission

Under the New Zealand Public Health & Disability Amendment Act 2010, the Health Quality and Safety Commission, established in 2010, is charged with:

- Providing advice to the Minister of Health on how quality and safety in health and disability support services may be improved.
- Leading and coordinating improvements in safety and quality in health care.
- Identifying key health and safety indicators (such as events resulting in injury or death) to inform and monitor improvements in safety and quality.
- Reporting publicly on safety and quality, including performance against national indicators.
- Sharing knowledge about and advocating for safety and quality.[13]

As part of this project, we spoke to the Health Quality and Safety Commission, and asked if they saw an on-going quality improvement process such as implementing NZGRS and unit-level accreditation as part of their role. The Commission's view was that, at present, they take action in areas which come to their attention through, for example, a high number of complaints or serious incidents, and where there is a clearly defined activity that they can implement a time-limited programme to improve. Their successful project to reduce Central Line Associated Bacteraemia was cited as an

[12] Ministry of Health, *Credentialing Framework for New Zealand Health Professionals,* 2010, p.2.

[13] http://www.hqsc.govt.nz/about-the-commission/our-role/, accessed 27 March 2015.

example of such a project. They did not see that the Commission was a suitable home for an on-going quality improvement programme, nor does the Commission have a legislative mandate or funding to undertake unit-level accreditation.

Template for Written Feedback

If you wish to provide written feedback, please review the questions listed below, and answer and provide specific answers to those on which you have a view. You can leave blank any questions you do not wish to answer. There is room at the end of the template for you to make general comments.

Your details

- Your name:
- Your organisation:
- Do the views in this set of comments represent your personal view or the view of your organisation?

Questions

Question 1: Do you agree with the objectives for a national structure outlined in section 2.3? What would you change/suggest?

Question 2: Do you support a National Endoscopy Leadership Group? Would your organisation nominate a member for such a group? Are there other organisations or interests that should be represented on this group? How often should such a group meet?

Question 3: Do you agree with a dedicated governance group for NZGRS and accreditation? Why/Why not? If yes, which organisations or groups do you think need to be represented on the NZGRS and accreditation governance group?

Question 4: Do you agree that the governance of training should continue to be undertaken by the existing professional organisations (i.e., the Colleges)?

Question 5: Do you agree with the overall national structure outlined in section 2 and summarised in figure 2? What would you change/suggest?

Question 6: Which funding model do you support at this stage and why?

Question 7: Do you agree with the high level description of a quality improvement programme in section 4.3? What changes or suggestions do you have?

Question 8: Do you agree with the high level description of a quality assurance programme in section 4.4? What changes or suggestions do you have?

Question 9: Do you agree that the QI and QA programmes should be separate? Why or why not?

Question 10: Do you have any other comments you wish to make on the content of this report?