

BreastScreen

AUSTRALIA

A joint Australian, State and Territory Government Program

BREASTSCREEN AUSTRALIA NATIONAL ACCREDITATION HANDBOOK

Updated under the auspices of the BreastScreen Australia Accreditation Review Committee

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GLOSSARY OF TERMS

Accreditation Survey	An external review of a Service and/or SCU performance against the national Program standards, based on the NAS Measures, and undertaken by a team of professional peers and the National Surveyor.
BreastScreen Australia	BreastScreen Australia is the national population-based screening program for breast cancer. BreastScreen Australia services are delivered by state and territory governments, through dedicated, accredited Screening and Assessment Services, which provide breast screening in over 600 locations nationwide.
BreastScreen Australia Data Dictionary	The authoritative source of data definitions used by BreastScreen Australia to meet the need for national consistency in the data collected for program monitoring and evaluation.
Client Management System	The database which stores a client’s personal, demographic and clinical outcome data. In Multi-Service Jurisdictions, each Service may have its own Client Management System, or there may be a statewide database. In some cases, this may also be referred to as the ‘registry’.
Conditional accreditation	Conditional accreditation is awarded to (i) new Services to allow them to become operational and (ii) Services and/or SCUs that need to address a number of quality improvement issues identified by the NQMC in order to be or remain accredited as a BreastScreen Australia provider.
Data Assessors	Data Assessors form part of the Accreditation Survey team and are responsible for undertaking a Data Governance and Management Assessment of the SCU/Service being accredited.
Data Governance and Management Assessment	An independent assessment of a Service and/or SCUs policies and processes that are in place to ensure effective governance and management of BreastScreen data. These policies and processes must meet those requirements as outlined in the National Accreditation Standards (NAS).

Decision Tool	The Decision Tool, developed to assist the NQMC in making accreditation decisions, allocates Measures to one of three risk levels; describes a tiered accreditation system; and links accreditation decisions to performance against NAS Measures.
Establishing Authority of the NQMC	Responsible for endorsing and appointing the Chair, members and proxies of the NQMC. This responsibility lies with the First Assistant Secretary, Population Health Division, Australian Government Department of Health.
Fixed site	A screening and/or assessment clinic that is permanent and does not relocate to alternate locations.
Full Accreditation	A level of accreditation that does not include a requirement to meet specific conditions in order for the Service and/or SCU to remain accredited.
Interim Survey	A scaled-down version of a survey may be requested by NQMC to address significant quality issues and/or risks.
Mobile Unit	A mobile unit 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.
NAS Accountability Framework	In multi-service jurisdictions, a 'NAS Accountability Framework (NAF)' is required to allow the NQMC to understand the accountability at a Service and SCU level. When making accreditation decisions, the NQMC considers the NAF in conjunction with the overall performance of the Service and/or SCU against all NAS Measures.
NAS Annual Data Report	A report provided annually to the NQMC by Services and/or SCUs, outlining performance against the quantitative NAS Measures.
NAS Data Measures	The quantitative NAS Measures defined by a required minimum or maximum performance level, as listed in the NAS data report form.

National Quality Improvement Framework	A framework which outlines the process through which quality issues identified within BreastScreen Australia are managed to drive continuous quality improvement at a national, state and service level.
National Surveyor	The person (or persons) employed nationally to coordinate, lead and attend all BreastScreen Australia accreditation surveys, to ensure consistency across survey teams nationally.
Pre- Commencement survey	A type of survey undertaken before a new Service is established or a new unit opened.
Program, or the Program	The BreastScreen Australia Program, the national, organised population-based screening program for the early detection of breast cancer that commenced in 1991.
Program Manager	The person in each jurisdiction who is responsible for representing their jurisdiction at national forums, contributing to the leadership of the national Program, implementing, coordinating and managing the delivery of breast screening services within that State or Territory. In multi-service jurisdictions the Program Manager is also responsible for managing the relationship between the State Coordination Unit and the individual Services. In jurisdictions where the provision of screening is overseen by a board of management, the Program Manager is also responsible for reporting performance to the Board.
Protocol	<p>Protocols determine the policies, procedures and principles that need to be implemented by BreastScreen Services and/or SCUs to underpin high quality service delivery and support the achievement of the BreastScreen NAS.</p> <p>Compliance with the Protocols is not measured or assessed by the NQMC in determining accreditation status. The exception is the Standard 5 Protocols, which are assessed for compliance under the Data Governance & Management Assessment.</p>
Screening Unit	A component of a Screening and Assessment Service that can be a mobile or fixed site that only provides screening.

Service	In single-service jurisdictions of ACT, NT, SA, TAS and WA, the Service and the SCU have shared management, governance and service delivery responsibilities. However multi-service jurisdictions (such as NSW, QLD and VIC), the Service and the State Coordination Unit (SCU) have separate and clearly defined areas of responsibility relating to management, corporate and clinical governance and service delivery. This document refers to 'Service and/or SCU' when accreditation processes need to occur which could be either the responsibility of the Service or the SCU.
Service Director	The person responsible for the day-to-day management of a particular Service within a jurisdiction.
Single Service Jurisdiction	A state or territory that has only one Service operating to cover the whole jurisdiction, and where the Service and the SCU have shared management, governance and service delivery responsibilities. These jurisdictions currently include the ACT, NT, TAS, SA and WA.
Multi-Service Jurisdiction	A state or territory which has more than one Service operating in the jurisdiction, and where the Services and the SCU have differing management, governance and service delivery responsibilities. These jurisdictions currently include NSW, QLD and VIC.
State Coordination Unit	The State Coordination Unit (SCU) provides state level stewardship of the Program and undertakes a range of functions that provide the infrastructure to manage and support high quality delivery of the BreastScreen Australia Program within a jurisdiction, in accordance with national policies, to ensure the achievement of the Program aims and objectives.

State Quality Committee	The role of the State Quality Committee (SQC) is to drive quality improvement at a jurisdictional level by monitoring the performance of its BreastScreen Services, advising on best practice principles, learning from adverse incidents, systematically addressing areas of risk across the jurisdiction and recommending strategies that will achieve continuous enhancement of breast screening services provided to women within that jurisdiction.
Surveyors	Accreditation surveyors form part of a multidisciplinary team to conduct an independent review of the Service and/or SCU against the NAS
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.
Website	The Australian Government Department of Health's cancer screening website . Websites for state and territory BreastScreen programmes can be found under the Useful Links page on this website.

LIST OF ACRONYMS

AHMAC	Australian Health Ministers' Advisory Council
ARC	BreastScreen Australia Accreditation Review Committee
BSA	BreastScreen Australia
NAF	NAS Accountability Framework
NAS	National Accreditation Standards
NQMC	National Quality Management Committee
SAS	Screening and Assessment Service
SCoS	Standing Committee on Screening
SCU	State Coordination Unit
SQC	State Quality Committee

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FOREWORD

The BreastScreen Australia accreditation system underpins the quality of services delivered by the Program and drives continuous quality improvement to ensure women receive safe, effective and high-quality care. The National Quality Management Committee (NQMC), as the national body with responsibility for accreditation and quality improvement, is committed to sustaining and strengthening the quality of breast screening services.

I would like to acknowledge the outcomes of the 2011-2014 review of BreastScreen Australia's accreditation system, overseen by Dr Heather Buchan as Chair of the Accreditation Review Committee. The review has resulted in a streamlined set of accreditation standards and a strengthened, more transparent and accountable process for assessing and awarding accreditation to BreastScreen Services and State Coordination Units (SCUs).

The NQMC has been afforded the authority by the Standing Committee on Screening (SCoS), to undertake future reviews of the accreditation system and provide revisions to the SCoS for endorsement. The new accreditation system has provided a strong foundation upon which the NQMC can continue to monitor the accreditation standards and governance arrangements, to ensure the system continues to be efficient, effective and drive quality improvement for the national program.

Transition to new accreditation system and review of implementation

The NQMC is well positioned to support the transition to the new accreditation system and monitor its impact on BreastScreen Services, SCUs and stakeholders involved in accreditation. It is proposed that two years after roll-out, the NQMC will undertake a review of implementation, including identifying areas for improvement and lessons learned.

Throughout the transition, the NQMC would welcome feedback from stakeholders about any components of the new system which may require clarification or refinement. The NQMC Secretariat will provide a central point of contact for these issues, which will also help to inform the review of the implementation process.

I look forward to working with you as we implement the new accreditation system and ensure the continued provision of safe, effective and high-quality screening and assessment services.



Dr Julie Thompson
NQMC Chair

1

INTRODUCTION

1.1 PURPOSE OF THIS HANDBOOK

The Accreditation Handbook is intended as a guide to achieving accreditation for BreastScreen Australia Services and State Coordination Units (SCUs). It aims to inform all those involved in accreditation about the requirements of the BreastScreen accreditation process; and the governance arrangements that underpin the BreastScreen Australia accreditation system.

The key accreditation documents for BreastScreen Australia include the:

- Accreditation Handbook;
- National Accreditation Standards (NAS); and
- suite of accreditation forms.

The Standing Committee on Screening (SCoS) has overseen the development of this Handbook in close consultation with stakeholders. Copies of materials related to BreastScreen accreditation are available from the Australian Government Department of Health's [cancer screening website](#).

1.2 OVERVIEW OF THE BREASTSCREEN AUSTRALIA PROGRAM

The BreastScreen Australia Program aims to reduce morbidity and mortality from breast cancer through an organised systematic approach to the early detection of breast cancer using screening mammography.

Screening mammography detects unsuspected cancer at an early stage so that early treatment can reduce illness and death from breast cancer.

This population based approach encourages asymptomatic women in the target population to have regular screening mammograms. It is distinctly different from the use of mammography to investigate symptoms in an individual woman, which is a diagnostic procedure. A central tenet of the success of BreastScreen Australia is to maximise the benefits of early breast cancer detection while minimising potential harm to women.

Women with symptoms of breast cancer or at high risk of breast cancer may need individualised care and services that are different from those provided through the screening program.

BreastScreen Australia's accreditation system intends to drive continuous quality improvement in the delivery of breast screening services to ensure women receive safe,

effective and high quality care.

1.2.1 Objectives of the BreastScreen Australia Program

The objectives of the BreastScreen Australia program are to:

- Reduce the mortality and morbidity attributable to breast cancer.
- Maximise early detection of breast cancer in the target population.
- Maximise the proportion of women in the target population who are screened every two years.
- Provide high quality services that are equitable, acceptable and appropriate to the needs of the population and equally accessible to all women in the target age group.
- Provide screening and assessment services in accredited Screening and Assessment Services as part of the BreastScreen Australia program.
- Provide high standards of program management, service delivery, monitoring, evaluation and accountability.

1.2.2 National Program Features

BreastScreen Australia services will be delivered in accordance with the following national program features.

Access and participation

Appropriate levels of access and participation in the target and eligible populations:

- women are eligible and invited for screening on the basis of age alone. That is, women aged 40 years and above are eligible to participate and recruitment strategies are targeted at women aged 50–74 years;
- the screening interval is every two years;
- screening is provided at minimal or no cost to the women, and free of charge to eligible women who would not attend if there were a charge; and
- patterns of participation should be representative of the socioeconomic, ethnic and cultural profiles of the target population.

Cancer detection

Breast cancer detection is maximised and harm is minimised:

- screening employs mammography as the primary screening method;
- all women are screened with two view mammography. Reasons for any variation from this policy are documented;

- all mammograms are taken by a mammography practitioner or radiographer appropriately trained in screening mammography;
- all mammographic images are read and reported independently, in a blind relationship, by two or more readers, at least one of whom shall be a radiologist; and
- all mammography results are combined into a single recommendation, which indicates whether or not further assessment for the presence of breast cancer is required.

Assessment

Assessment and diagnosis of breast cancer is appropriate, safe and effective:

- a comprehensive approach is employed in the assessment of breast abnormalities;
- a multidisciplinary team is involved in the assessment of women recalled from screening;
- the pre-operative diagnosis of breast cancer is maximised, and recommendations for surgery for benign lesions are minimised;
- the outcomes for all women recommended for surgery are collected, reviewed and utilised in continuing professional education for members of the multidisciplinary team; and
- women's general practitioners are kept informed of the results of screening and assessment, unless a woman requests otherwise.

Timeliness

Screening and assessment services are provided to women in a timely and efficient manner:

- women have timely access to screening;
- the time from screening to assessment is minimised; and
- the results of screening and assessment are provided promptly and directly to the woman concerned in ways which are sensitive to her possible anxiety.

Data management and information systems

Effective data and information management systems:

- data are collected, stored and managed using secure, quality, contemporary data management and communication systems that comply with relevant state and national standards, and that enable valid, reliable system and service performance analysis and evaluation;
- data are used for strategic purposes, quality improvement of services and for clinical and service management;
- data are collected in line with the requirements of the BreastScreen Australia Data

Dictionary; and

- data are to be submitted annually to the Australian Institute of Health and Welfare, for use in a national program monitoring report, and annual performance data reports for review by the National Quality Management Committee.

Client focus

Services are of high quality and client focused:

- high quality information is provided to inform women, and women feel appropriately engaged and supported;
- screening services are provided in a manner which is acceptable to women in accessible, non-threatening and comfortable environments;
- women and health care providers are given comprehensive and easily understood information about the Program, from screening up to and including diagnosis of breast cancer;
- counselling and information are an integral part of the Program;
- women are advised of the benefits and risks of mammography; and
- women are provided with written information and actively involved in decisions about their management, particularly in relation to further assessment and treatment.

Governance and management

Effective structures and processes are in place to ensure high quality governance and management:

- screening and assessment are carried out at BreastScreen Australia accredited services; and
- key stakeholders and stakeholder groups participate in the monitoring and management of the Program.

1.3 BACKGROUND TO ACCREDITATION

1.3.1 Purpose

The accreditation process aims to strengthen and sustain the quality of service provision to ensure women receive breast screening services that keep pace with best practice standards and are safe, effective and of a high quality.

1.3.2 History

The Australian Health Ministers' Advisory Council (AHMAC) agreed in 1990 to establish a national mammographic screening program. The AHMAC stipulated that, to ensure quality,

mammography screening and assessment of women with screen detected breast abnormalities should only be performed by Services that are accredited.

In 1991 the Commonwealth Minister for Health established the then National Accreditation Committee (now NQMC) to the National Program for the Early Detection of Breast Cancer (now BreastScreen Australia).

1.3.3 Key Components of the Accreditation Process

To achieve accreditation, a Service/SCU needs to demonstrate to the NQMC, as the accreditation decision-making body, that it meets the National Accreditation Standards to an acceptable level.

Key components of the accreditation process include:

- developing, monitoring and implementing a quality improvement (QI) plan that is reviewed regularly;
- undertaking a self-assessment against all NAS Measures at least once every 12 months;
- providing an Annual Data Report every 12 months to the NQMC;
- participating in an accreditation survey every four years (and possible interim, unscheduled or internal surveys as requested by the NQMC and/or state bodies); and
- participating in a Data Governance and Management Assessment every four years.

1.4 ACCREDITATION REVIEWS

1.4.1 1991-1994

The first National Accreditation Requirements were developed and implemented when BreastScreen Australia commenced in 1991. These requirements were reviewed and revised in 1994.

1.4.2 1999-2002

The NQMC initiated a second review of the National Accreditation Requirements in 1999. The review involved consultation with the State and Territory BreastScreen Programs, 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 National Advisory Committee (NAC)¹, and became operational on 1 July 2002.

¹ In 2004, the National Advisory Committee was replaced by the Australian Screening Advisory Committee. In 2006 the Screening Subcommittee was established, and in 2012, it was renamed as the Standing Committee on Screening.

In February 2003 the NAC endorsed a Decision Tool to support accreditation decision-making using the NAS.

1.4.3 2011-2014

In April 2011, the BreastScreen Australia Accreditation Review Committee (ARC) was established to oversee a comprehensive review of the accreditation system, including the NAS, governance arrangements and accreditation process. Three subcommittees of the ARC were established to undertake specific streams of work under the review, including the:

- NAS and Data Subcommittee;
- Performance Improvement and Governance Subcommittee; and
- Pilot and Implementation Subcommittee.

The review was undertaken in a collaborative and consultative manner, with stakeholder engagement of BreastScreen Australia Program representatives, clinicians, professional colleges and members of the community through a series of workshops followed by an online survey.

The review has resulted in a revised accreditation system that builds on the success of the previous system, but which is streamlined, strengthened and improved for the future.

2014 Review Outcomes – NAS

- The NAS were reviewed and reduced from 173 individual quantitative and qualitative NAS to 42 NAS Data Measures.
 - The NAS Data Measures are supported by a set of qualitative Protocols, which outline the policies, procedures and principles that underpin high quality service delivery and will facilitate the achievement of the NAS. The protocols are intended to facilitate Services and/or SCUs to improve service delivery and drive quality improvement in the event of declining performance or difficulty achieving the respective NAS Measures.
- NAS that were previously reported to the Australian Institute of Health and Welfare were not altered to maintain longitudinal data integrity and continuous Program monitoring.
- Measures covered by jurisdictional and/or Commonwealth legislation were removed to avoid duplication.
- A number of new Measures were inserted to ‘future proof’ the accreditation system; and collect data to inform development of future policy.

2014 Review Outcomes – Governance

- The governance structure for accreditation was updated and streamlined to provide an

increased focus on quality improvement at the jurisdictional and national level; improve consistency of the roles and responsibilities of jurisdictional governance bodies; and increase accountability and transparency of accreditation decisions.

- The NQMC has a strengthened capacity to strategically identify national trends and respond to emerging issues at a national level that relate to safety, quality and continuous program improvement.
 - The National Quality Improvement Framework (see [Attachment 1](#)) outlines how the NQMC will use information it receives (e.g. through accreditation applications and annual data reports), to identify issues and optimise performance of the national program. It is expected that the National Quality Improvement Framework will inform the development of jurisdictional Quality Improvement Frameworks by State Quality Committees (SQCs), to ensure a consistent approach to quality improvement throughout the Program.
- Jurisdictional governance bodies no longer assess applications for accreditation or recommend an accreditation rating to the NQMC. It is now the role of the SCU to check applications for accreditation are complete, prior to forwarding to the NQMC.
- Jurisdictions no longer require a State Accreditation Committee. Instead, it is expected that each jurisdiction has:
 - a SQC, responsible for driving quality improvement, providing strategic direction and policy oversight for BreastScreen Services within the jurisdiction; and
 - an SCU, responsible for ensuring the delivery of consistent, high quality BreastScreen Services within the jurisdiction; and to establish and support the functions of the SQC.

2014 Review Outcomes – Accreditation Process

- In addition to BreastScreen Services, SCUs are also required to undergo accreditation.
- To improve accountability, Services and SCUs are to be assessed against, and held accountable for their performance against NAS Data Measures for which they have responsibility. Delineation of responsibility between the Service and SCU is to be recorded on the NAS Accountability Framework, where appropriate, discussed further under Section 2.6.
- Accreditation surveys (previously termed site visits) are to be undertaken once every four years, regardless of the accreditation rating obtained by the Service and/or SCU. However, the requirement for Annual Data Reports has been retained.
- Data Governance and Management Assessments (previously Data Audits) are to be undertaken at the same time as the Accreditation Survey, with findings to be recorded on the survey report. For jurisdictions that have a central Picture Archiving and Communication System (PACS)/Client Management System, individual Services may not

need to undergo a Data Governance and Management Assessment, as this will be undertaken during the SCU Accreditation Survey. This will be contingent upon the NAF and may be requested by the SCU and/or NQMC.

2

GOVERNANCE STRUCTURE ROLES AND RESPONSIBILITIES

2.1 GOVERNANCE STRUCTURE

The governance structure that has been developed for the quality management of the BreastScreen Australia Program has four key areas of responsibility, which are based on Tricker's model of governance². These are:

- strategic planning and quality improvement;
- monitoring compliance;
- reporting; and
- policy oversight.

This model of governance has been adopted for each level of the Program's quality management structure; the National Quality Management Committee (NQMC); the State Quality Committees (SQCs); the State Coordination Units (SCUs); and the Screening and Assessment Services (Services). Each level has a defined role in these four key areas of responsibility for accreditation and quality improvement to ensure a consistent approach across the BreastScreen Australia Program.

While the governance arrangements may differ from state to state, it is expected that in addition to the SCU and Service, each jurisdiction will have a SQC at a minimum.

2.2 THE NATIONAL QUALITY MANAGEMENT COMMITTEE (NQMC)

2.2.1 NQMC Role and Responsibilities

The role of the BreastScreen Australia NQMC is to make decisions regarding the accreditation of BreastScreen Australia Services and the Program's SCU. These decisions are based on a comprehensive process of review and assessment of performance against the National Accreditation Standards (NAS), using standard data Measures and the independent observation by a multi-disciplinary team of surveyors contained in the survey report.

² Robert I. Tricker, *International Corporate Governance: Text Readings and Cases*, New York: Prentice Hall, 1994

The NQMC, through the accreditation process, is also able to strategically identify national trends and respond to emerging issues at a national level relating to safety, quality and continuous program improvement. Therefore, the broader role of the NQMC is to provide a national level of Program governance that ensures that the BreastScreen Australia Program achieves its aims and objectives through the provision of effective and efficient, high quality breast cancer screening services. The four key areas of governance responsibility for the NQMC detailed below.

Strategic planning and quality improvement

- Develop a national quality improvement (QI) plan for the BreastScreen Australia Program to assist with strategic planning and quality improvement, which aligns with the National Quality Improvement Framework.
- Provide strategic leadership and monitor the quality of services delivered by BreastScreen Australia Services to lead continuous quality improvement.
- Collect national accreditation data for the defined set of NAS Measures to monitor, analyse and report trends to the Program Management Group, SCoS and to SCUs/Services.
- Receive, review and analyse reports from SCUs on any major systems, Service or SCU performance failures that occur within the Program.
- Report the occurrence of major adverse events to the Standing Committee on Screening (SCoS) as appropriate and develop and implement national QI strategies to minimise the occurrence or recurrence of any major system, Service or SCU performance failures.
- Monitor the feedback process between the BreastScreen Services and the SCUs to ensure service/jurisdictional level QI plans are developed in line with the national QI plan. These should be implemented and monitored on a regular basis, to address issues requiring quality improvement within the Service.
- Identify service delivery excellence and examples of best practice and use these to model improvement and initiatives across the Program.

Monitoring compliance with the standards

- Review and assess submissions for accreditation and Annual Data Reports from BreastScreen Services and SCUs and award an accreditation status commensurate with their performance.
- Make recommendations and provide formal written feedback to the BreastScreen Services and SCUs, and the relevant state or territory Departments of Health that identify areas that require quality improvement.
- Govern the BreastScreen Australia surveyor program.

Reporting

- Document and publicly report on the accreditation status achieved by each BreastScreen Service and SCU.
- Provide reports on accreditation status against the NAS Measures to national, state and territory governments through the Standing Committee on Screening (SCoS) as appropriate.
- Document and report on the national performance of BreastScreen Australia Services and SCUs against the NAS Measures to facilitate benchmarking across jurisdictions and drive quality improvement.

Oversight of policy and standards setting for the Program

- Provide advice and recommendations to the SCoS, informed by analyses of performance trend data on emerging issues or trends and policy gaps.
- Review and recommend new or amended accreditation standards, for approval by the SCoS.
- Provide policy advice to the Australian Health Minister's Advisory Council and SCoS on how to enhance clarity and consistency of the national Program.

2.2.2 NQMC Chair

The Chair of the NQMC will be external to BreastScreen Australia. The Chair will have the following attributes:

- skills in chairing high level meetings;
- skills and experience relating to accreditation;
- knowledge of population based cancer screening programs;
- credibility within their field of health expertise and public standing.
- sufficient time to attend all NQMC meetings and undertake out-of-session work as required.

The Establishing Authority of the NQMC is responsible for endorsing and appointing the Chair of the NQMC. This responsibility lies with the First Assistant Secretary, Population Health Division, Australian Government Department of Health. As the NQMC reports to the SCoS, nominations for the NQMC Chair may be undertaken in collaboration with the SCoS.

2.2.3 NQMC Acting Chair

If the appointed chair is not able to attend a meeting due to unforeseen circumstances a member of the committee can take on the role as chair. This member must be the nominated proxy for the chair, endorsed by the Establishing Authority for the NQMC, and as

outlined in the NQMC Member Guidelines.

2.2.4 NQMC Membership

The membership of the NQMC is predominately skills based and are not necessarily representatives of clinical colleges or jurisdictions involved in BreastScreen Australia. All members must have relevant knowledge and skills related to BreastScreen Services. This includes:

- knowledge of and expertise related to population based cancer screening programs
- skills and experience relating to accreditation;
- credibility within their field of health expertise and public standing; and
- sufficient time to attend most NQMC meetings and undertake out-of-session work as required.

The process for seeking nominations for member and proxy appointments to the NQMC is as follows:

- The NQMC Secretariat will seek nominations from jurisdictions, including Service Directors, Program Managers and state/territory Departments of Health;
- Nominees will be requested to submit a CV and covering letter identifying their appropriate skills and expertise for the nominated position;
- If more than one nomination is received for a position, Program Managers will be asked to confidentially recommend their preferred candidate;
- Where appropriate, the NQMC Secretariat may seek the support or endorsement by the relevant college of the nominated NQMC member;
- The NQMC Secretariat will advise the First Assistant Secretary, Population Health Division of the Australian Government Department of Health, the Establishing Authority of the NQMC, who will endorse and appoint the members of the NQMC;
- Nominations for NQMC members may be undertaken in collaboration with the SCoS.

The membership of the NQMC is as follows:

- Radiologist
- Radiographer
- Commonwealth appointed member
- Jurisdictional appointed member (with skills in BreastScreen Australia Program Management)
- Epidemiologist
- Data manager

- Pathologist
- Surgeon
- SQC Chair (this position to rotate on an annual basis)
- Consumer advocate
- Patient safety and quality representative

The employed National Surveyor will attend all NQMC meetings as an observer. Where additional skills are required, the NQMC may establish time limited reference groups, specific to issues requiring expert and /or clinical advice. The NQMC may also co-opt additional members where relevant, for fixed term projects.

2.2.5 NQMC Terms of Appointment

The terms of appointment for the NQMC are:

- members will be appointed for an initial term of up to three years, with no member serving more than two consecutive terms;
- the NQMC membership will be reviewed in accordance with the membership rotation strategy contained in [Attachment 6](#). This will ensure continued corporate knowledge and experience, while maintaining transparency and accountability of the NQMC through the introduction of new members; and
- proxies will be appointed to attend meetings when members are unavailable.
- The State Quality Committee Chair position role on the NQMC rotates on an annual basis. The rotation arrangement involves the following occurring at each anniversary of the appointment of the State Quality Committee (SQC) Chair roles:
 - the SQC Chair Member role will be vacated;
 - the SQC Chair Proxy will be appointed into the vacant SQC Chair Member role;
 - a new SQC Chair from another jurisdiction will be invited to be appointed to the SQC Chair Proxy role according to the following rotation order:
 1. Tasmania
 2. Northern Territory
 3. Victoria
 4. Queensland
 5. New South Wales
 6. Western Australia
 7. South Australia
 8. Australian Capital Territory
 - If a jurisdiction chooses to decline its scheduled participation, the offer will go to the next jurisdiction in the rotation and the declining jurisdiction will be given first offer

the following year. Further, if the SQC Chair in a jurisdiction is already an NQMC Member or Proxy, that jurisdiction will be skipped.

2.2.6 NQMC Meetings

The NQMC meets quarterly at a minimum, usually in March, May, August and November.

2.2.7 NQMC Secretariat

The NQMC is supported by a Secretariat whose role includes:

- Prepare performance information on accreditation on behalf of the NQMC for provision to the SCoS.
- Facilitate the development/maintenance of all processes and documentation associated with accreditation.
- Working with the BreastScreen Australia National Surveyor to support the accreditation survey process.
- Coordinate feedback in accordance with the accreditation survey feedback forms (see Section 7.4) and provide de-identified information to individual survey team members and the National Surveyor to drive continuous quality improvement of the survey process.
- 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 (including findings against the Decision Tool) and the reasons for the decision.
- Process application forms (see [Attachment 3](#) for the NQMC checklist) and provide written advice to the Service, SCU and state/territory Department of Health of the NQMC's decision on accreditation, including provision of a Certificate of Accreditation to the Service and/or SCU.
- Maintain a record of all certificates issued and the accreditation status of each Service and SCU.
- Send reminders to the SCU before the expiry of the accreditation of each Service/SCU.
- Maintain and update the BreastScreen Australia accreditation database.
- Undertake analysis of data within the accreditation database to assist the NQMC in identifying performance trends and strategic issues for the national program.
- Provide secretariat support for appeal committees.
- Advise the appellant in writing of appeal outcomes.

2.3 THE STATE QUALITY COMMITTEE (SQC)

2.3.1 SQC Role and Responsibilities

The role of the SQC is to drive quality improvement at a jurisdictional level by monitoring the performance of its BreastScreen Services, advising on best practice principles, learning from adverse incidents, systematically addressing areas of risk across the jurisdiction and recommending strategies that will achieve continuous enhancement of breast screening services provided to women within that jurisdiction.

The four key areas of governance responsibility for accreditation and quality improvement for the SQC detailed below.

Strategic planning and State level quality improvement

- Provide leadership and advice to the SCU and/or Service on the development, implementation and ongoing review of a state QI plan, which should align with the national QI plan.
- Provide strategic leadership and advice on best practice principles to ensure sound clinical governance is maintained across the State/Territory Services and the SCU.
- Consider the impact of unmet Measures, with regard to their risk categorisation and the over-arching Standard, to recommend strategies which should be developed and implemented by the Services and/or SCU to improve performance.
- Review any system, Service or SCU performance failures and make recommendations on actions to be taken to ensure continuous QI at the Service and jurisdictional level. This will include making recommendations to the SCU about the issues that should be escalated and reported to the NQMC so that national QI strategies can be developed to minimise further occurrence or recurrence across the Program.
- As appropriate, in collaboration with the SCU liaise with any relevant committee, Board or College to advise the Services and/or relevant clinicians and/or SCU on issues of a clinical nature that require the implementation of QI strategies.

Monitoring and compliance

- Review jurisdictional level data and identify trends where quality improvement strategies may be required to improve performance against the BreastScreen Australia NAS.
- Provide advice on addressing any quality issues reported by stakeholders, clients or local consumers that impact on performance and/or compliance with the NAS.

Reporting

- Provide reports to the NQMC, through the SCU, on key issues for the jurisdiction with

respect to QI as required.

- Report to the NQMC, through the SCU, on major system or performance failures at the Service or SCU level, the actions taken and QI strategies developed and implemented.

Policy oversight

- Provide leadership and direction to the SCU to ensure national policies and priorities are implemented in the jurisdiction.
- Provide leadership and direction to ensure consistent implementation of jurisdictional policies and protocols across and within Services. This includes making recommendations regarding state policies and protocols, to ensure consistency across the Program at a jurisdictional level.

2.3.2 SQC Membership

Consistency is required at a national Program level regarding the governance role of the SQCs. However, the management of the committee, including the nomination and appointment of the SQC Chair and members is the responsibility of each jurisdiction. Therefore, the SQC membership and meeting arrangements described below are provided as a guide, while providing flexibility for states and territories to establish the committee to meet their needs.

While it is at the discretion of each state and territory to determine the SQC membership it is recommended that it is a skills based committee. The SCU will appoint the members and support the operations of the SQC. The recommended expertise and skills for committee members are as follows:

- A person with expertise in health systems or clinical governance/QI.
- A person(s) with expertise in the delivery of breast screening services and skills in:
 - radiation safety; and/or
 - image acquisition and quality; and/or
 - screen reading; and/or
 - the assessment process.
- A person with expertise in analysis of BreastScreen data.
- A consumer with knowledge of breast screening.
- A clinical leader, or person with operational experience at a Screening and Assessment Service (Service) level.
- A representative from the SCU.
- A representative from the state or territory Department of Health (e.g. State Manager, Cancer Services).

2.3.3 SQC Chair

A chair should be appointed by the SCU, and have appropriate skills and expertise to provide strategic leadership and advice in the development, implementation and monitoring of quality improvement initiatives across the jurisdiction.

2.3.4 SQC Membership Renewal and Participation

SQC membership will be at the discretion of the SCU and encourage succession planning and capacity building of expertise in quality assurance and quality improvement within the Services.

2.3.5 SQC Meetings

The SQC should ideally meet monthly to support the monitoring of quality initiatives and incident monitoring. Provision should be made for ad hoc or executive meetings to be arranged if there are issues requiring urgent attention.

2.4 THE STATE COORDINATION UNIT (SCU)

2.4.1 SCU Role and Responsibilities

The role of the SCU is to provide consistent, high quality delivery of the BreastScreen Australia Program within a jurisdiction, in accordance with national policies, to ensure the achievement of the Program aims and objectives. A key role of the SCU is to operationally support the Services and committees such as SQC, consumer reference groups, clinical advisory committees, recruitment and communication committees and service based quality committees.

The SCU provides state level governance and stewardship of the Program and undertakes a range of functions that provide the infrastructure to manage and support the Program. This includes; strategic state level policy and Service planning; management and maintenance of the integrated Client Management System and Picture Archiving and Communication System (PACS); quality monitoring and evaluation; collation and analysis of state and Service performance data; data provision and reporting; workforce planning and training; and development of communication strategies and resources.

The four areas of governance responsibility for accreditation and QI for the SCU are detailed below.

Governance, strategic planning and state level quality improvement

- Governing and managing the BreastScreen Services in accordance with relevant state and national policies, standards and guidelines.
- Ensure expertise is present within, or available to provide advice to, the SCU on issues

relating to corporate and clinical governance.

- Where appropriate, develop the jurisdictional NAS Accountability Framework (NAF) in consultation with Services and other relevant stakeholders (e.g. Local Health Districts).
- Identify and address jurisdiction wide quality issues through ongoing performance monitoring and the implementation of the jurisdictional QI Plan developed by the SQC.
- Collect, collate and analyse Service and jurisdictional level accreditation data against all performance measures, and provide an accurate and comprehensive source of Program data for that jurisdiction.
- Provide copies of the jurisdictional QI Plan (developed by the SQC) to:
 - The NQMC, to assist in identifying national performance trends and QI strategies for the Program.
 - The relevant Director of cancer screening services within the State or Territory Department of Health, where the SCU is separate to the Department.
 - The Service Director and Clinical Director of each BreastScreen Australia Service within the jurisdiction.
- Provide Annual Data Reports to the SQC for performance monitoring of the jurisdiction as a whole and individual Services against the accreditation Standards, to enable analysis, interpretation and identification of performance issues and trends across the jurisdiction.
- Ensure that any system or Service performance failures that occur within the jurisdiction are reported to the SQC. The report should clearly outline any investigations and follow-up activities undertaken by the SCU and/ or the Service to minimise further occurrence or recurrence in the future.
- Work in partnership with Services to ensure QI plans are developed, implemented and monitored on a regular basis, to address issues requiring improvement within the Service.

Service compliance and coordination

- Work with the National Surveyor to plan and coordinate the accreditation surveys of Services within the State or Territory in the agreed timeframes.
- Notify the NQMC if the Service is not able to meet the agreed timeframe and/or if there are significant quality issues with a Service.
- Notify the Service eight months prior to the end of the four year accreditation cycle that an application for accreditation is required.
- Provide central coordination for all accreditation documentation and surveys.
- Provide central coordination for liaison and communication from the Service

Director/Clinical Director to the NQMC. The NQMC will liaise directly with the SCU, which will promptly provide information to the Service.

- Work with the NQMC Secretariat to ensure all accreditation documentation is submitted to align with the NQMC quarterly meeting schedule and that it is comprehensive, complete, timely and includes a copy of the where relevant.
- Monitor and analyse Service level accreditation data, and provide feedback to Services to address areas requiring improvement against accreditation standards and measures. Present this information to the SQC meetings.
- Monitor the completion of Service self-assessment reports and QI plans to ensure jurisdictional level policies and quality improvement strategies are being implemented consistently at a Service level.
- Undertake internal surveys of Services where falling performance or areas of concern have been identified, and work with the Service to implement quality improvement strategies to address the areas of concern. Ensure compliance with all relevant national standards as required, including; BreastScreen Australia standards; the Australia Commission on Safety and Quality in Health Care, National Safety and Quality Standards; and State/Territory policy and legislative requirements.

State Coordination Unit compliance

- Provide high quality services in the jurisdiction by ensuring compliance of the SCU against relevant BreastScreen Australia policies, NAS, as outlined in the NAF, where relevant.
- Maintain a state level integrated PACS and client management system (where possible), of the screening and assessment of all women.
- Develop and maintain data governance and management processes that are quality assured for data security, accuracy, integrity and organisation, including:
 - system based validation processes;
 - ensuring the information systems are audited and regularly generate reports;
 - developing and implementing data quality assurance processes to ensure the integrity, quality and accuracy of data across all Services within the jurisdiction, using data definitions in accordance with the BreastScreen Australia Data Dictionary.
- Develop and maintain a risk management and data security plan.

Reporting

- Report to the NQMC, a summary of any major system, Service or SCU performance issues and the actions taken, so that national quality improvement strategies can be developed to minimise occurrence or recurrence of any such issues across Australia.

- Provide data to the NQMC for purposes of national quality improvement.
- Report relevant data to the Australian Institute of Health and Welfare.
- Provide reports to the Board and/or State/Territory Department of Health as appropriate and required.
- Provide reports to external national or state agencies as required.

Policy

- Develop and monitor state level policies and protocols for implementation by the Services/SCU having regard to; best practice principles; relevant national clinical guidelines; existing legislation; and national policy and priorities, to ensure consistency in service delivery across the jurisdiction.
- Develop policies and protocols in consultation with the Services and other relevant stakeholders, such as clinical professional organisations and consumers.
- Ensure that policies and protocols are informed by an analysis of state and national level performance data to ensure quality and consistency for women screened in that jurisdiction.
- Identify service delivery and capacity issues that could be addressed through the development and implementation of state level policies.
- Contribute to the development of national policies as required.

2.5 BREASTSCREEN AUSTRALIA SERVICES

2.5.1 Roles and Responsibilities

The role of BreastScreen Australia Services is to provide consistent, high quality breast cancer screening and assessment services to eligible women in their catchment. These services are delivered in accordance with BreastScreen Australia policy and state level policies and protocols, to ensure the achievement of the Program's aims and objectives.

The Services are required to attain and maintain accreditation in the BreastScreen Australia Program to be acknowledged as part of the Program. The accreditation of the Services provides women who participate in the Program with an assurance that the individual Service is of a high quality and meets the standards required for the delivery of a BreastScreen Australia service.

The four areas of governance responsibility for accreditation and quality improvement for the BreastScreen Services are detailed below.

Strategic planning and quality improvement

- Establish and maintain governance and management structures, in particular clinical

governance.

- Establish and maintain clinical leadership across all disciplines working in the Program with a focus on continuous quality improvement.
- Establish partnerships between the SCU and Services to achieve accreditation to a high standard and implement quality improvement strategies.
- Develop an annual plan for service provision that ensures appropriate access for women in the catchment, particularly those women that may be disadvantaged socially, culturally or geographically.
- Develop, implement and review a Service level QI plan that includes clear lines of clinical and management responsibility and aligns with jurisdictional and national QI plans.
- Engage with local stakeholders formally and informally, including consumers, to ensure local level input to planning processes and quality improvement strategies.
- Work to implement effective locally based health promotion and recruitment strategies.

Monitoring and compliance

- Maintain a focus on continuous quality improvement by monitoring Service performance against the NAS Measures.
- Monitor Service performance against the QI plan and take action as needed to address any system or Service failures.
- Notify the SCU of any system or Service failures, actions taken or planned and work with the SCU and SQC to ensure that effective quality improvement strategies are implemented.
- Monitor compliance with all quality assurance processes for the Service equipment and ensure compliance with State/Territory legislative and national/state professional requirements.

Reporting

- Provide reports as required to state and local health service management and stakeholders.
- Report to the SCU and, if required the SQC, on unmet NAS Measures, including planned QI strategies to enhance performance.
- Ensure that quality assurance reports for the clinical disciplines are disseminated as appropriate, documented and recorded.
- Generate system reports for operational quality assurance monitoring and quality improvement as appropriate.

Policy

- Implement state level policies and protocols to ensure consistency in service delivery across the jurisdiction.
- Develop local operational procedures that align with national and state policies and protocols.
- Work in partnership with the SCU to develop and revise state level policies and protocols as appropriate.
- Identify any policy gaps, issues or constraints and inform the SCU and/or SQC.

2.6 BREASTSCREEN AUSTRALIA NAS ACCOUNTABILITY FRAMEWORK

In multi-service jurisdictions, where appropriate, a 'NAS Accountability Framework (NAF)' is required to ensure the NQMC can consider the accountability at a Service and SCU level when assessing performance against NAS Measures. In single service jurisdictions a NAF is not required as the Service and SCU have shared responsibility for all NAS Measures.

The NAF should be developed in collaboration with Services, to delineate the NAS that are the responsibility of the SCU and those that are the responsibility of the individual Service within the jurisdiction. Establishing a NAF in each jurisdiction will take into account the differing business and service delivery models that are in place across Australia and ensure that each agreement is tailored to meet the needs of the individual jurisdiction.

The NAF will classify each NAS Measure into one of three categories. Those:

1. which are solely the responsibility of the Service;
2. which are solely the responsibility of the SCU; and
3. for which there is shared SCU and SAS responsibility, or where there is a level of interdependence between two Measures.

An example of a Measure which would fit into the third category is as follows. The SCU may be responsible for sending women invitations to participate in the Program, but the Service may be responsible for allocating screening appointments. In this case, Measure 1.1.1b) "≥70% of women aged 50-69 years participate in screening in the most recent 24 month period", would have joint responsibility by the Service and SCU.

In this circumstance, if the Measure is not met, it should be recorded as 'unmet' on both the Service's and SCU's application for accreditation.

While it is likely that most jurisdictions will have one NAF, there may be jurisdictions that have a different NAF with each Service. To provide an example, one Service within a jurisdiction may read its own images and would therefore be responsible for cancer detection, however another Service may send its images to be read centrally within the jurisdiction (i.e. by a distributed reading model overseen by the SCU), and therefore, the Service and the SCU would be jointly responsible for cancer detection. Consequently, these

two Services would require a different NAF.

The NQMC will use the relevant NAF to consider all applications for accreditation and to award Services and SCUs with an accreditation status. It is a decision for the individual Service and SCU to agree the delineation of responsibilities as outlined in the NAF. The NQMC should accept the completed NAF as an agreed document between the Service and SCU.

A template for a NAF can be accessed in the suite of forms (see Section 5.8).

3

ACCREDITATION DECISION- MAKING, DECISION TOOL AND APPEALS

3.1 NQMC AUTHORITY AND TRANSPARENCY

The authority for decision-making regarding the accreditation of individual BreastScreen Australia Services and/or State Coordination Unit's (SCUs) rests with the National Quality Management Committee (NQMC). While the requirements for levels of performance set out in Table 1 guide the NQMC's decision-making, the NQMC may vary from these requirements provided there is sufficient justification. In any such cases, the NQMC's reasons will be fully documented and communicated in writing to the relevant Service and/or SCU, the respective state or territory Department of Health and survey team.

There is an internal review and appeals process for NQMC decisions, outlined in Section 3.5.

As it is a government committee bound by Commonwealth administrative law provisions, NQMC deliberations and decisions may also 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.

3.2 NQMC DECISION-MAKING

In making accreditation decisions, the NQMC considers the balance of the performance of Services and/or SCUs across all National Accreditation Standard (NAS) Measures, using the performance targets in the Decision Tool (refer to 3.3) to determine an appropriate accreditation status. While accreditation decisions are based on the Decision Tool, the NQMC also considers the overall context of performance, including all of the information and data presented as part of the application, including the survey report as well as the multidisciplinary and expert discussions held at its meetings. This is designed to ensure a focus on quality improvement rather than solely an audit process.

Members of the NQMC who are associated with the Service or SCU being discussed, or who work in the SQC 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 surveyor or Data Assessor for a Service or SCU being considered for accreditation will not contribute to discussion in relation to their experience in this role but are included in the decision-making and voting process. 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 on behalf of the NQMC, 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.

3.2.1 Assessment of Service and SCU Performance

Each Service and SCU will be assessed and subsequently awarded an accreditation status by the NQMC, based on its performance against all accreditation Measures, while taking into account Service and SCU responsibility against NAS Measures as outlined in the NAF.

A Service's application for accreditation should include Service level data for all NAS Measures. A SCU's application for accreditation should include state wide data for all NAS Measures.

For multi-service jurisdictions, the overall accreditation status that the NQMC awards an SCU will not impact on the accreditation status of individual BreastScreen Services within the jurisdiction. However, for those accreditation Measures which have shared SCU and Service responsibility within the NAF, if the Measure is deemed to be unmet, it will be recorded as unmet on both the SCU's and the Service's application for accreditation. This will be taken into consideration when the SCU's and Service's application for accreditation is assessed against the Decision Tool.

While the protocols outlined in the NAS document are not measured during the Accreditation Survey, they may form part of the validation of the self-assessment for the purpose of accreditation. The protocols are the underpinning principles that guide and ensure consistent quality of services and should be the primary reference in the event of declining performance or Service's difficulty achieving the respective NAS Measures. The protocols are also a tool for the development of quality improvement strategies.

3.2.2 Revisions of Accreditation Status

The NQMC may review the accreditation status of a Service and/or SCU at any time during the accreditation cycle. Such a review may result in the NQMC upgrading or downgrading the accreditation status of a Service or SCU.

The following will apply if a mid-accreditation term review leads the NQMC to consider an accreditation downgrade:

- If the review identifies performance issues which are not considered to involve an immediate and significant risk of a Level 1 adverse event occurring, the NQMC will, prior to making a decision to revise the accreditation status of a Service/SCU, either:

- undertake a 'show cause' process³ requesting further information; or
 - commission an Interim Survey.
- If the NQMC considers that there is an immediate and significant risk of a Level 1 adverse event occurring, the NQMC may immediately downgrade the accreditation status.

3.2.3 Use of Confidence Intervals

In assessing performance against quantitative indicators, the NQMC considers outcomes within 95% confidence intervals. This is particularly critical in the case of Services which screen or assess small numbers of women, where performance may vary from the Measure as a result of chance.

Therefore, it is important that SCUs/Services report against confidence intervals wherever possible in addressing Measures that are technically unmet and just on the borderline of being met. SCUs and Services should also provide any information available to support consideration of the Measure as being met, such as aggregated data that can increase interpretive power or demonstrate trends.

Where performance is outside the absolute requirement set for the Measure, but within the confidence interval, close monitoring should be implemented by the Service and/or SCU. It is recognised that not all Services and/or SCUs will meet all of the NAS Measures. If a measure is not achieved, the reasons should be analysed and targeted strategies for improvement implemented.

Where a Measure is not met and a confidence interval is supplied by a Data Report (either in an application or in an Annual Data Report), the NQMC will apply the following rules in its decision-making:

- Performance falling within the 95% confidence interval will be considered a necessary but insufficient condition for accreditation decision-making purposes; and
- Additional sources of evidence will be used by the NQMC to support accreditation decision-making. These sources may include aggregated data, additional historical data, the small numbers index, survey reports, and the opinion and experience of other committee members.

The rationale behind these rules is outlined in [Attachment 5](#).

The NQMC will consider awarding accreditation where Measures are unmet, based on the reasons provided for not meeting the Measure, demonstration of quality improvement

³ The show cause process is a mechanism by which the NQMC will state its intention to revise the accreditation status of a Service/SCU *unless* provided with relevant and sufficient evidence to the contrary within a specified timeframe.

processes and targeted strategies for improvement, and trend data to indicate that performance is improving over time.

3.3 DECISION TOOL

Due to the impact on the BSA Program of the COVID pandemic, from 5 March 2021 until further notice, this Section 3.3 will not apply and is replaced by the arrangements outlined in [Attachment 7](#).

The Decision Tool:

- links accreditation decisions to performance against the National Accreditation Standard (NAS) Measures (refer to Section 3.3.1)
- allocates Measures to one of three risk levels, categorised in relation to key performance outcomes (refer to Section 3.3.2); and
- describes a tiered accreditation system (refer to Section 3.3.3).

The Decision Tool outcome is calculated on basis of Service and/or SCU performance against all NAS Measures. To ensure transparency of NQMC accreditation decisions, the Decision Tool is available to all involved in the accreditation process.

3.3.1 Decision Tool Performance Targets

Table 1 outlines the performance to be achieved by Services and/or SCUs across the NAS Measures to achieve certain levels of accreditation. These performance targets assist the NQMC in its decision-making process to accredit Services and/or SCUs based on their performance against the NAS Measures.

Table 1: Decision Tool performance targets for each accreditation tier*

Accreditation level	Required performance target against NAS Measures
Accredited with commendation	The Service and/or SCU must achieve: <ul style="list-style-type: none"> • All level 1 Measures; and • 90% of level 2 and level 3 Measures combined.
Accredited	The Service and/or SCU must achieve: <ul style="list-style-type: none"> • All but one of the level 1 Measures; and • 80% of level 2 and level 3 Measures combined.
Conditional accreditation	The Service and/or SCU service must achieve: <ul style="list-style-type: none"> • All but two of the level 1 Measures; and • 75% of level 2 and level 3 Measures combined.
Non-accredited	Where a Service and/or SCU does not meet at least the requirements for Conditional accreditation, following a six month remediation period or where accreditation has lapsed.

* A description of each accreditation tier is provided at Section 3.3.3

Note: The targets outlined in Table 1 will be used to inform accreditation decisions for single-service jurisdictions and most multi-service jurisdictions. However, the NQMC can use its discretion to agree an appropriate accreditation rating based on the Service and/or SCU's performance against the Measures for which it is accountable under the NAS Accountability Framework.

3.3.2 Risk Levels for NAS Measures

The Decision Tool employs a risk management approach to decision-making. Risk management is well recognised as an objective way to provide a structure for decision-making 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 practice.

Each NAS Measure is allocated a risk rating/level as a way to consider the impact on BreastScreen Australia clients if that Measure was not met. The allocation of risk ratings does not mean that some Measures are more important, as all the NAS Measures are important for ensuring quality of service. Risk categorisation is simply a method of assessing the impact of a Service and/or SCU performing poorly against a Measure.

The level of risk allocated to each Measure was informed by the AS/NZS ISO 31000:2009 – risk management - principles and guidance. This risk management approach describes the combined effect of likelihood and consequence, which have been used to develop three risk categories for NAS Measures as follows:

- Level 1: Extreme and high risk
- Level 2: Moderate risk
- Level 3: Low risk.

Table 2 below summarises the number of Measures per risk level in each Standard. A complete list of all Measures within each Standard, categorised by risk level, is set out in detail in [Attachment 2](#).

Table 2: Summary of the number of Measures per risk level per Standard

Standard	Ranking of Measures by risk level		
	Level 1 (extreme/high)	Level 2 (moderate)	Level 3 (low)
Access and Participation	-	4	1
Cancer Detection	3	15	4
Assessment	4	3	1

Timeliness	1	7	-
Data Management and Information Systems	-	1	1
Client Focus	-	-	-
Governance and Management	-	-	-
Total for each risk level	8	30	7
TOTAL NAS Measures	45		

A list of the Level 1 NAS Measures is detailed below.

Standard 2: Cancer Detection

- 2.1.1** a) The Service and/or SCU monitors and reports the proportion of women aged 50–74 years who attend for their first screening episode who are diagnosed with invasive breast cancer.
b) ≥ 50 per 10,000 women aged 50–69 years who attend for their first screening episode are diagnosed with invasive breast cancer.
- 2.1.2** a) The Service and/or SCU monitors and reports the proportion of women aged 50–74 years who attend for their second or subsequent screening episode who are diagnosed with invasive breast cancer.
b) ≥ 35 per 10,000 women aged 50–69 years who attend for their second or subsequent screening episode are diagnosed with invasive breast cancer.
- 2.1.3** a) The Service and/or SCU monitors and reports the proportion of women aged 50–74 years who attend for their first screening episode who are diagnosed with small (≤ 15 mm) invasive breast cancer.
b) the Service and/or SCU monitors the proportion of women aged 50–74 years who attend for second or subsequent screening episode who are diagnosed with small (≤ 15 mm) invasive breast cancer.
c) ≥ 25 per 10,000 women aged 50–69 years who attend for screening are diagnosed with small (≤ 15 mm) invasive breast cancer.

Standard 3: Assessment

- 3.1.4** $\leq 0.35\%$ of women who attend for their first screening episode are found not to have invasive breast cancer or DCIS after diagnostic open biopsy.
- 3.1.5** $\leq 0.16\%$ of women who attend for their second or subsequent screening episode are found not to have invasive breast cancer or DCIS after diagnostic open biopsy.
- 3.1.7** $\geq 95\%$ of all lesions are correctly identified at first excision.

- 3.1.8** a) ≥85% of invasive breast cancers or DCIS are diagnosed without the need for excision.
- b) Where part a) is not met, the Service and/or SCU provides the proportion of breast cancers that are diagnosed as invasive and DCIS without the need for excision.

Standard 4: Timeliness

- 4.2.1** a) ≥90% of women requiring assessment attend an assessment visit within 28 calendar days of their screening visit.
- b) Where part a) is not met, the Service and/or SCU records and reports the number of days the Service and/or SCU takes to achieve 90%.
- c) Where part a) is not met, the Service and/or SCU records and reports the percentage of women who were offered assessment within 28 calendar days of their screening visit.

3.3.3 Tiered Accreditation

There are four levels of accreditation with non-accreditation also a possible outcome. A new Service comes into the Program at the conditional accreditation level. A description of each accreditation level is provided below.

Accredited with commendation

This is the highest level of accreditation awarded. The Service and/or SCU is recognised for high performance against all Measures for which they have sole/shared responsibility.

Accredited

BreastScreen Australia Services and SCUs that achieve this level of accreditation must perform highly against most Measures for which they have sole/shared responsibility, including all but 1 of the level 1 Measures and 80% of level 2 and 3 Measures.

Conditional accreditation

Existing Services and/or SCUs

Conditional accreditation is awarded to Services and/or SCUs that need to address a number of quality improvement issues identified by the NQMC in order to be or remain accredited as a BreastScreen Australia provider. Services and/or SCUs that achieve this level of accreditation are expected to have met all but 2 of the level 1 Measures and 75% of level 2 and 3 Measures.

While conditional accreditation is awarded for a period of four years, should the Service and/or SCU feel that it has sufficiently addressed the quality improvement issues identified by the NQMC, the Service and/or SCU may seek to upgrade its level of accreditation at any time from two years after accreditation was granted (at the time it would be submitting its second ADR since the accreditation application). This will be at the expense of the

individual jurisdiction and a request will need to be sent outlining how the Service and/or SCU has addressed the QI issues identified to the NQMC Secretariat (see Sections 5.3 and 6.5).

New Services

Conditional accreditation is the entry level of accreditation to allow new Services to become operational and enable them to develop the potential to achieve full accreditation. Services that have become non-accredited will also use conditional accreditation to re-enter the Program.

A new Service can choose to apply for full accreditation a minimum of two years after it has been granted conditional accreditation. This is to ensure that the new Service has sufficient time in which to become established and to collect data to support its application for full accreditation. Before the end of the four year conditional accreditation period, the Service Director should commence work with the SCU to apply for full accreditation.

SCU Provisional accreditation

Provisional accreditation is the once-off, entry level of accreditation for multi-service SCUs agreed by the NQMC. SCUs have two years from the date of obtaining Provisional accreditation to apply for full accreditation.

Non-accredited

A Service and/or SCU will not be accredited if it does not meet at least the requirements for conditional accreditation following a six month remediation period, or if accreditation has lapsed (see Section 6.7).

Services and/or SCUs that do not meet the requirements for conditional accreditation will be given six months to show improvement or risk being non-accredited. Remedial actions should be undertaken with direct involvement from the respective state/territory government and the jurisdictional SCU and/or SQC.

While it is acknowledged that it is likely to take more than six months for improvement in performance to show in data trends, it is considered that within six months, work should have commenced to develop and implement strategies to improve the clinical and corporate governance issues associated with the Service and/or SCU's poor performance. QI plans and a demonstrated commitment to improve performance should be provided to the NQMC to inform any future action or decision which may be required by the NQMC to monitor the ongoing performance of the Service and/or SCU.

If, after the six month remediation period, a Service and/or SCU is still unable to meet the requirements for conditional accreditation, the Service and/or SCU will be deemed to be non-accredited. Non-accreditation will mean that the Service and/or SCU will not be able to:

- Operate as a BreastScreen Australia Service.
- 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 auspice of the Program may undermine the integrity of the Program, and most importantly, potentially put clients and staff at risk. A non-accredited Service in this situation should undertake careful risk management planning with the relevant State/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 conditional 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, re-commences operations. Data pertaining to periods before the application by the Service for conditional accreditation is not relevant on the basis that it relates to the previous structure and operation that would be expected to have changed significantly to address the reasons for non-accreditation.

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

3.3.4 Categorising Performance against Individual NAS Measures

There are four ways in which the performance of a Service and/or SCUs can be categorised against a NAS Measure. The Measure can be considered to be:

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

Unable to be assessed

This category applies in situations where no sound information or data is available to assess performance. For example, a new Service may not have been operating long enough to collect enough data to measure its performance against a particular Measure. For the purpose of calculation of accreditation against the Decision Tool, Measures that are 'unable to be assessed' are considered to be 'unmet'.

Unmet

A Measure is considered '*unmet*' where there is data or other evidence available to determine that the required measure has not been attained.

Met

A Measure is considered '*met*' where there is evidence available to determine that the required performance level has been attained.

Met with exception

To be classified as '*met with exception*', performance against a Measure must be very close to meeting the absolute measure. The '*met with exception*' category is applied to those Measures prefaced with the word 'all' or a standard of 100% or 0%. However, in addition to these Measures, the NQMC also retains its discretion to assess on a case by case basis if any other Measure should be determined to be '*met with exception*'. For example, where outcomes of Measures are impacted by the number of women screened and small numbers. Supporting information from the Service and/or SCU will be required and used by the NQMC to inform its decision. This should include explanatory information as well as information on the strategies in place to enable the Measure to be met.

3.4 AFTER AN ACCREDITATION DECISION IS MADE BY THE NQMC

To ensure confidentiality, NQMC members must ensure application documents are destroyed after an accreditation decision is reached. The Secretariat will keep one copy on file as a record. The Australian Government Department of Health is also provided with a copy by the Secretariat for its records.

After each NQMC meeting, the NQMC Secretariat updates the national accreditation status report, which is then published on the Department of Health's cancer screening website. The NQMC then advises the Service and/or SCU in writing of its decision, together with a summary of its assessment of the Service and/or SCUs accreditation submission. A high level report of the Service's performance history will be published on the Department of Health's cancer screening website. Releasing this information will help ensure public accountability and transparency of the Program, and through this, help drive quality improvement. The information will be released in a consistent format and will include the level of accreditation achieved, areas in which the Service and/or SCU has performed well, and areas in which the Service and/or SCU could improve performance.

The NQMC Secretariat also notifies the relevant Department of Health, National Surveyor and survey team of the outcome of accreditation for quality improvement purposes.

All Services and/or SCUs achieving accreditation receive a certificate from the NQMC Secretariat acknowledging their success. A separate certificate will be supplied for each unit within a Service. Certificates must be displayed by Services in a prominent position where they can be seen by consumers.

3.5 APPEAL OF DECISIONS

The appeals process is premised upon the collaborative working arrangements between Services, SCUs and the NQMC to achieve accreditation for the Service.

3.5.1 Right of Appeal

Any Service (through the SCU) and/or SCU has the right to appeal a decision made by the NQMC in relation to their accreditation status.

The appeal should be made in writing from the SCU to the Chair of the NQMC within four weeks of the receipt of notification of the accreditation outcome letter from the NQMC. 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 (BSA201).

The Chair of the NQMC will formally acknowledge receipt of the appeal in writing to the SCU within five working days of receiving the appeal letter.

The accreditation status held by the Service or SCU prior to the accreditation decision which is under appeal will remain in force until the appeal is finalised.

3.5.2 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 perceived to be 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; or
- other reasons that would need to be substantiated.

3.5.3 NQMC Consideration of Appeal

In the first instance, the NQMC will consider the appeal, reviewing its original accreditation decision and recommendations. In undertaking this internal review:

- The NQMC will have a formal discussion⁴ with the appellant about the grounds for their appeal.

⁴ This will involve the appellant being invited to participate in a discussion on their appeal in the NQMC meeting at which the internal review is considered.

- The NQMC may inspect the premises of the Service and/or SCU; invite any relevant person to appear before the NQMC, including Survey Team members; or seek additional information from the Service, SCU or State Quality Committee (SQC).
- The NQMC will take into account any new information submitted by the appellant.

If the NQMC considers that it should change its original decision on the basis of new information provided, it will set aside its original decision and replace it with a new decision. Where no new information is provided by the appellant, the NQMC must conduct its internal review on the basis of the information considered in arriving at the original decision.

Should the NQMC decide by consensus to change its accreditation decision, it will notify the SCU in writing within 10 working days.

If the NQMC decides by consensus to retain its original accreditation decision, then the appeal escalates to a review by an external Appeals Committee and the SCU will be notified in writing that an Appeals Committee will be appointed and a meeting convened.

3.5.4 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 review the NQMC's original accreditation decision.

The appeals committee will comprise at a minimum:

- the chair or delegated member of the Standing Committee on Screening. 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 Australian Government Department of Health;
- a BreastScreen Australia Program representative such as a Service Director (they must not be from the same jurisdiction as the appealing Service and/or SCU);
- a consumer representative, who may be a member of the NQMC; and
- an Australian Government representative who is not a member of the NQMC.

Depending on the issues to be considered, the appeals committee may also include a representative of the legal profession, an epidemiologist, an expert in patient safety and quality and any other professional expertise required.

No person with a conflict of interest, for instance a current or past employee of the appealing SCU or Service, is to take part in an appeals committee. All members of an appeals committee will be required to sign a deed of 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 including the National Accreditation Standards, the Handbook including the Decision Tool and any other documents of relevance. Members will also be provided with copies of the accreditation application and all supporting documents provided to the NQMC by the SCU and the NQMC original decision. If necessary, the appeals committee may request clarification of issues from the appealing Service and/or SCU.

Reimbursement of costs to eligible members of an appeals committee will be the responsibility of the jurisdictional SCU. [Attachment 4](#), "Payment and travel requirements for surveyors and Data Assessors" provides an indication of costs.

3.5.5 Consideration of Appeals

The appeals committee will review the accreditation process applied and the accreditation decision awarded by the NQMC having regard to the evidence presented to it. This may include a request by the committee for a representative of the Service and/or SCU to appear before the committee. At the conclusion of the review, the committee will provide a recommendation to the NQMC regarding the outcome of accreditation, which may include a request for the NQMC to reconsider further documentation to be provided by the Service and/or SCU.

All members of the appeals committee, including the chair, are entitled to vote. The appeals committee recommendation 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 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 level of accreditation; or
- re-survey of the relevant premises, in whole or in part, including a new survey.

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 process or recommendation.

The review decision should be finalised within three months of receipt of the 'Appeal Application' form. The NQMC Secretariat will advise the appealing Service and/or SCU in writing of the appeal outcomes as soon as possible after the appeals committee has made its decision.

3.5.6 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 Australia entity 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.

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 and/or SCU 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.

3.5.7 Administration of Appeals Committees

To support the appeals process the NQMC Secretariat will:

- ensure that those on the appeals committee receive information on the BreastScreen Australia Program and appeals process as required;
- provide members of an appeals committee with confidentiality and declaration of interest forms prior to the appeals committee being convened;
- maintain the original signed copies of these forms for the records;
- provide secretariat and all other administrative support to the appeals committee and keep records of appeal decisions on file, and provide a record of appeal decisions to the Australian Government Department of Health; and
- advise the appellant in writing of the appeal outcomes.

4

KEY COMPONENTS OF THE ACCREDITATION PROCESS

4.1 QUALITY IMPROVEMENT PLANS

QI Plans are required to be developed and implemented at a Service, jurisdictional and national level and these must be monitored and reviewed at regular intervals.

As outlined in Section 2.3, the State Quality Committee (SQC) and/or SCU in each jurisdiction is responsible for developing, monitoring and implementing a QI Plan for the relevant state or territory. It is important that the QI Plans developed for Services and SCUs are in alignment with, and complement the jurisdictional QI Plan developed by the SQC and/or SCU whilst also addressing specific, local issues relevant to the Service/and or SCU.

As outlined within the National Accreditation Standards (NAS) commentary, the QI Plan should include clear lines of clinical and management responsibility within the Service and/or SCU, and identify strategies for each component of the screening and assessment pathway that will support and enhance the quality of breast cancer screening services for women. The QI Plan should also include specific strategies to improve performance against any unmet NAS Measures, or when declining performance trends are identified within the Service and/or SCU.

A template QI Plan has been developed for use by Services and/or SCUs within the suite of forms (BSA006). The Service and/or SCU QI Plan must be submitted to the NQMC on this template as part of an application for accreditation.

4.2 SELF-ASSESSMENT

All Services and/or SCUs must undertake at least annually a self-assessment against all NAS Measures to drive quality improvement and identify areas which are done well, and those requiring improvement. Each Service and SCU is required to submit an Annual Data Report to the NQMC. The NAS Data Report form should be used to undertake self-assessment and is provided in the suite of forms (see Section 5.8).

Self-assessment is also required to support an accreditation application. This takes the form of a review prior to a scheduled accreditation survey, with documentation of performance against all NAS Measures, and consideration of the risks as outlined in the Decision Tool (see Section 3.3).

When issues are identified through the self-assessment process quality improvement strategies must be developed to reduce or remove risks. These should be documented in

the Service and/or SCU QI Plan and regularly monitored and reviewed by management and staff. If necessary, issues may need to be managed in accordance with the incident management process outlined in Section 9.3.

4.3 ANNUAL DATA REPORTS

The NQMC requires annual data reports to be submitted from every Service and SCU. These reports inform the accreditation process and allow the NQMC to monitor performance between accreditation periods.

Annual Data Reports are based on the most recently available data for either calendar or financial years and are required to be submitted to the NQMC every 12 months from the date the Service and/or SCU was awarded accreditation by the NQMC.

4.3.1 SCU Annual Data Report

Every SCU must submit an Annual Data Report (using BSA004) which includes statewide data for each NAS Measure. This provides the NQMC with a holistic view of the performance of the jurisdiction, to help identify any performance issues or trends and inform the development of any quality improvement strategies that may need to be implemented across the jurisdiction.

For single-service jurisdictions, it is acknowledged that the Annual Data Report will include data against each NAS Measure for both the Service and the SCU.

For SCU Annual Data Reports, the SCU is expected to provide state wide Quality Improvement Plans only for unmet NAS Measures for which they are responsible.

4.3.2 Service Annual Data Report

For multi-service jurisdictions, the Annual Data Report for each Service/SCU is to include data against each NAS Measure, regardless of whether the Measure is the responsibility of the Service or the SCU. This will require information to be provided by both the Service and SCU and will provide the NQMC with a holistic view of the performance of the Service.

Services in multi-service jurisdictions are expected to provide information about their Quality Improvement Plans for unmet NAS Measures, including state wide Quality Improvement Plans for NAS Measures that are the responsibility of the SCU.

The NAS Data Report template (BSA004) should be used to complete the Annual Data Report.

Annual Data Reports should include a response for all unmet Measures using the Response by Service/SCU Form (BSA005). The SCU and/or SQC are required to work with the Service to identify and implement quality improvement strategies to address areas of concern. A copy of the Service and/or SCU QI plans should also be provided to the NQMC.

Where an Annual Data Report indicates significant falling performance or areas of concern, the NQMC may request an interim survey(s) be undertaken of the Service and/or SCU, which would include a review of the accreditation status.

Note: Annual data reports must be provided to the accreditation survey team before a survey.

4.4 ACCREDITATION SURVEYS

Each Service and SCU must undergo a formal accreditation survey once every four years. The survey is conducted by a BreastScreen Australia accreditation survey team, led by the National Surveyor. The purpose of the survey is to:

- validate the self-assessment of BreastScreen Services and SCUs against the NAS Measures; and
- provide educative and learning opportunities to facilitate continuous quality improvement for the Service and/or SCU.

There are five types of accreditation surveys which may be undertaken as part of the accreditation process for Services and/or SCUs:

- a full accreditation survey, which includes a Data Governance and Management Assessment;
- an interim accreditation survey;
- an unscheduled accreditation survey;
- an internal accreditation survey; and
- a pre-commencement survey for new services (see Section 5.6).

Section 5.1 of the Handbook provides detailed information about the process for undertaking an accreditation survey.

4.5 DATA GOVERNANCE AND MANAGEMENT ASSESSMENT

Undertaking Data Governance and Management Assessments is a key part of the BreastScreen Australia accreditation system. Data Governance and Management Assessments are intended to achieve national consistency regarding:

- the collection and reporting of outcome data across jurisdictions and BreastScreen Services;
- business processes to ensure data is of a high quality, valid and collected in accordance with the specifications of the BreastScreen Australia Data Dictionary; and
- the interoperability between the Picture Archiving and Communications System (PACS) and Client Management System.

Data Governance and Management Assessments are undertaken every four years as part of an accreditation survey. Further information about the process for undertaking Data Governance and Management Assessments is detailed within Section 5.7.

5

ACCREDITATION SURVEYS AND DATA GOVERNANCE AND MANAGEMENT ASSESSMENT

5.1 FULL ACCREDITATION SURVEY

An accreditation survey is an external review of a Service and/or State Coordination Unit (SCU) based on the BreastScreen Australia National Accreditation Standards (NAS), and undertaken by a team of professional peers and overseen by the National Surveyor. The principles of the survey are based on the two objectives of accreditation survey systems, to enable continuous quality improvement through:

- validating self-assessing against standards; and
- providing educative and learning opportunities for all participants to facilitate continuous quality improvement.

During the survey, a Data Governance and Management Assessment will also be conducted by the Data Assessor of the survey team (see Section 5.7).

Every Service and SCU will undergo an accreditation survey once every four years, covering all service units, including mobiles and fixed sites. However, should the NQMC be concerned about the performance of a Service, it may request that an interim survey be undertaken within the four year period.

The schedule for undertaking surveys will be negotiated with the National Surveyor, SCU and each Service within the jurisdiction, and should aim to be staggered across the four year period.

For 'single-service' jurisdictions the SCU and the Service are integrated, and therefore, the survey will occur concurrently. For 'multi-service' jurisdictions, the SCU survey will occur separately, although a Service survey could also be undertaken at the same time as the SCU survey, if required. The accreditation survey will assess the SCUs performance against the accreditation Measures for which it is responsible, as described in the NAF (see Section 2.6).

For jurisdictions that have a central Client Management System/PACS, individual Services will not be required to undergo Data Governance and Management assessment, this will be undertaken during the SCU survey.

For Services within jurisdictions that do not have a centralised ICT system, a Data

Governance and Management Assessment will be undertaken during the Service's formal accreditation survey.

A full survey of a Screening and Assessment Service (Service) is a thorough process, usually taking between two and three days to complete. A survey of a SCU should be completed within one day.

5.2 SCOPE OF THE SURVEY

Each component of the Service should be visited, whether mobiles or fixed sites. 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 survey team over the period of the visit.

An exception to this would be where a fixed site or 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 survey team. Relevant documentation should be made available, and any other information, such as photographs or video recordings, and copies of images for quality assurance checks by the radiologist/radiographer on the survey team. If possible, staff from the fixed site or mobile unit should be available to meet the survey team or at least to talk to them by teleconference or videoconference.

If an interim survey (see Section 5.3) has been undertaken in the 12 months prior to the full survey to assess some components of the Service, documentation from this interim survey will be provided to the surveyors.

It is important that the survey focuses strictly and objectively on the performance and operation of the Service in relation to the NAS Measures, and not in relation to, or comparison with any other Service.

5.3 INTERIM SURVEYS

An interim survey is a scaled-down version of a full survey and can be instigated by the NQMC, SCU or SQC 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.

Interim surveys will be undertaken by an external, national BreastScreen Australia Survey Team, which will be appointed by the National Surveyor. The membership of the team will be selected to reflect the unmet NAS Measures and other identified issues.

Examples of when an interim survey may be undertaken are as follows:

- the NQMC requests the Service and/or SCU to undergo an interim survey if it is concerned about the performance of an accredited Service and/or SCU in maintaining the quality of service commensurate with its accreditation level;

- the Service and/SCU applies to the NQMC for an upgrade of its accreditation status; or
- A Service and/or SCU is unable to arrange for all units to be made available or accessed at the time of a full survey.

If a Service is required to undergo an interim survey, they will need to work collaboratively with the SCU to prepare for the visit. SCU staff may need to travel to the Service prior to and during the visit to ensure quality reporting and service delivery. Full and complete information must be available to surveyors.

If a Service is unable to arrange for all units to be made available or accessed at the time of the full survey, an interim survey of one or more units at an earlier time, as close as possible to the time of the scheduled survey, should be arranged. Documentation should then be provided to the full survey 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 survey.

This option is to be used only in exceptional circumstances and must be supported by written advice from the SCU to the NQMC of the reasons for requesting the interim survey. Advice may be sought from the NQMC regarding the conduct of an interim survey. The National Surveyor can provide the list of available surveyors.

5.4 UNSCHEDULED SURVEYS

The NQMC reserves the right to request unscheduled surveys for underperforming Services and/or SCUs. These surveys would be similar to an interim survey (above) and be organised by the National Surveyor at the direction of the NQMC.

5.5 INTERNAL SURVEYS

An internal survey is employed as an internal quality assurance mechanism for multi-service jurisdictions where the SCU and/or the SQC may be concerned about the performance of a Service within that jurisdiction. Where a Service receives a conditional accreditation rating, an external survey will still only be undertaken every four years unless the NQMC requests an interim survey. However, the SCU and/or the SQC may choose to do an internal survey at any time if falling performance or areas of concern have been identified. The SCU will work with the Service to implement quality improvement strategies to address the areas of concern.

Examples of when an internal survey may be used are as follows:

- to monitor the performance of the Service, including the implementation of quality improvement strategies; or
- a new unit is added.

The selection and appointment of surveyors for an internal survey is the responsibility of the SCU, in consultation with its SQC. Advice may be sought from the NQMC.

Internal survey reports are usually not required to be submitted to the NQMC unless the SCU determines that the issues of concern are of a nature which requires national consideration and action.

Reports on internal surveys of new units must be included in the documentation for surveyors at the time of the next accreditation survey for a Service.

5.6 PRE-COMMENCEMENT SURVEYS

Pre-commencement surveys are undertaken when a new Service, or a new unit within a Service is established.

Pre-commencement surveys ensure that there are appropriate systems, workforce and operating procedures in place to enable the Service or unit to deliver high quality screening services. For new Services, the pre-commencement survey will also include a preliminary Data Governance and Management Assessment. This may be conducted as a paper-based assessment to ensure that the Service has the capacity to collect and report reliable, valid and high quality data, which meets the requirements of the BreastScreen Australia Data Dictionary.

5.7 DATA GOVERNANCE AND MANAGEMENT ASSESSMENT

During the survey, the Data Assessor will undertake a Data Governance and Management Assessment. This will assess the components of data governance and management that are the responsibility of the SCU or Service, including:

- compliance against the accreditation Measures within Standard 5 – Data Management and Information Systems;
- compliance against the protocols listed within Standard 5 (see Glossary: ‘Protocol’);
- the Picture Archiving and Communications System (PACS); and
- the operation, management and governance of the BreastScreen Client Management System.

The Data Governance and Management Assessment will be undertaken once every four years as part of the formal survey. The NQMC will however have the discretion to request the SCU or Service undergoes an additional assessment if it is concerned about its performance.

5.7.1 Centralised PACS/Client Management System

For jurisdictions that have a central PACS/Client Management System, only the SCU will undergo a Data Governance and Management Assessment. However, it remains the role of the SCU to ensure the consistency and high quality of information recorded in the BreastScreen Service Client Management System within the jurisdiction. This should be

undertaken through both systematic and random audits of Service level data by the SCU. During the Data Governance and Management Assessment, the SCU should provide the Data Assessor with evidence of the quality and consistency of data that is entered at each service within the jurisdiction.

The data submitted as part of a Service's application for accreditation should include data against only those accreditation Measures for which it has sole, or shared responsibility, as outlined in the NAF. This information will be used by the NQMC to determine an accreditation rating informed by the requirements of the Decision Tool.

5.7.2 Four Disciplines of Data Governance and Management

There are four disciplines of data governance and management that will be assessed by the Data Assessor. The following outlines the key areas that the Data Assessor will focus on when analysing data governance and management as part of the formal accreditation survey.

Discipline 1 - Data security

- Policies that minimise security risks to information and prevent unauthorised access to data. Policies should comply with national standards for information security management including AS/NZS ISO/IEC 27001:2006 and AS/NZS ISO/IEC 27002:2006.
- Role-based access levels, permissions and authorisation to data.
- Solutions that obscure client identities by modifying client-identifiable data while maintaining data quality. This should ensure data can be used for secondary purposes, e.g. national data analysis/research without compromising confidentiality. Data identifiability should be informed by the National Health and Medical Research Council's National Statement on Ethical Conduct in Human Research 2007 (updated 2013).
- Procedures that ensure security risks/breaches to the Client Management System and PACS are identified logged, reported and actioned.

Discipline 2 - Data quality

- Establishing data validation rules, processes and monitoring systems to ensure entered data conform to the data specifications as outlined in the BreastScreen Australia Data Dictionary regarding datatype (i.e. numeric/alphanumeric), field size, data domain etc.
- Developing query reports that relate to the quality of data within the PACS and/or Client Management System. These queries may be used to identify missing data, 'out-of-range' data or data that appear to be inconsistent. They may also be used to identify abnormal trends (e.g. an unexpected increase in recall to assessment/decrease in cancer detection etc).
- Establishing quality assurance mechanisms to ensure:

- the consistent application of algorithms as described in the BreastScreen Australia Data Dictionary. The Data Assessor may request a demonstration of how the results for specific accreditation measures are calculated.
 - data accuracy (the extent to which data in the Client Management System matches with source data); and
 - data completeness (extent to which all data that should have been registered have actually been registered).
- Processes to ensure the Client Management System is updated when any changes are made to the BreastScreen Australia NAS or data specifications/definitions within the Data Dictionary.

Discipline 3 - Data integrity

- Solutions that maintain the integrity of data transferred between systems (e.g. between the local BreastScreen Client Management System and statewide PACS or between the BreastScreen Client Management System and, if appropriate, external databases/systems), including processes to test data to eliminate bugs that may cause data loss or corruption during data storage or transfer.
- Establishing appropriate data integrity checks (including both routine and random audits) to ensure data conforms to the data validation rules (developed under *Item 2 – Data Quality*) after it has been created, stored, retrieved or transferred. These checks should highlight errors, inconsistencies and missing data so that they can be rectified by the Data Manager, or referred to the appropriate person for action.
- Mechanisms to ensure data transferred to other systems (e.g. between the SCU and Services, or externally to third party organisations) are secure and unable to be modified without prior authorisation (e.g. disabling fields). Where data are modified, integrity checks are built-in to ensure that data entered remotely complies with the validation rules developed under *Item 2 – Data Quality*.

Discipline 4 - Data organisation and systems management

- Establishing support management systems, including appropriate technical support, to address any issues in an effective and timely manner, whilst ensuring the Client Management System/PACS can continue operating to support service delivery requirements.
- Solutions that specify common standards for how clinical information is recorded, organised and managed within the PACS and/or Client Management System. This may include Integrating the Healthcare Enterprise (IHE) standards such as Health Level 7 (HL7) Clinical Document Architecture, Digital Imaging and Communications in Medicine (DICOM) or Systematised Nomenclature of Medicine – Clinical Terms Australia (SNOMED

CT-AU)⁵.

- The Data Assessor should assess the extent to which these solutions:
 - ◆ are adhered to, and consistently implemented within the Client Management System/PACS; and
 - ◆ enable interoperability for BreastScreen services within a jurisdiction and where possible, external to the jurisdiction, as well as external third party providers.
- Solutions to ensure seamless communication and information exchange between the statewide Client Management System/PACS and individual BreastScreen Client Management Systems within the jurisdiction.
- A comprehensive Data Management Manual (or equivalent) which includes but is not limited to:
 - All policies, procedures and protocols that are required for the effective management and governance of data within the PACS and Client Management System
 - Change management strategies
 - Training requirements.
- Processes to ensure back-up and disaster recovery of data within the PACS and Client Management System.

When assessing performance against disciplines 1, 2 and 3, the Data Assessor should undertake a 'risk-based approach to quality assurance'. This means focusing on the *"most important sources of error or procedural lapses from the perspective of the registry's purpose"*⁶. For example:

- ensuring all women's images are double read;
- where there has been a discordant read, the image has been referred for a 'consensus' or 'third' read;
- calculating Measures which could be subject to misinterpretation or inconsistent application of algorithms - e.g. time from screening to assessment;
- abnormal trend data – i.e. performance against accreditation Measures which appear to have suddenly increased or decreased compared to historical averages; or
- ensuring the accuracy of data entered by the Service with respect to assessment

⁵ Further information about SNOMED CT-AU is available from the [National E-Health Transition Authority \(NEHTA\) website](#)

⁶ Gliklich RE, Dreyer NA, editors. Registries for Evaluating Patient Outcomes: A User's Guide. 2nd edition. Rockville (MD): Agency for Healthcare Research and Quality (US); 2010 Sep.

outcomes; and,

- the process for matching with cancer registries for the purpose of validating interval cancers.

The Data Assessor's findings of the Data Governance and Management Assessment will be recorded on the Survey Report (BSA101). The SCU is responsible for addressing any areas identified for improvement through appropriate quality improvement strategies. This will ensure that the Service and/or SCU have effective policies, procedures and protocols that will ensure a high level of data security, accuracy, integrity and organisation and systems management.

The SCU's response to the Data Assessor's findings should be recorded on the 'Response by Service and/or SCU' accreditation form (BSA005), with quality improvement strategies outlined within the SCU's Quality Improvement Plan (BSA006).

5.8 SUITE OF FORMS

A suite of forms has been developed to support the accreditation process. These are available on the Department of Health's cancer screening website and include:

- BSA001 Application for Accreditation.
- BSA004 NAS Data Report.
- BSA003 NAS Accountability Framework.
- BSA101 Survey and Interim Survey report.
- BSA005 Response by Service/SCU.
- BSA002 Notification of Commencement of Service.
- BSA007 Request for Extension to Accreditation.
- BSA201 Appeal Application.
- BSA501 Deed Poll - Confidentiality and Conflict of Interest Undertaking.
- BSA009 Survey Evaluation Tool.
- [BSA010 Surveyor Evaluation Tool.]⁷
- BSA008 Report Evaluation Tool.
- BSA006 Quality Improvement Plan.
- BSA000 Protocol Management Checklist (available from the NQMC Secretariat upon request).

⁷ Implementation postponed.

- BSA301 Standard 5 Protocol Accountability Framework
- BSA302 – DGMA Self-assessment form
- BSA303 DGMA Data Assessor Report
- BSA304 DGMA Service/SCU response to DGMA

It is mandatory for Services and SCUs to use the forms as they have been designed to provide the NQMC with information essential to making accreditation decisions, and to assist in 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.

Please note: the QI plan template (BSA006) includes:

- Part A: is confined to issues relating to unmet NAS Measures, or declining performance trends within the Service/SCU; and
- Part B: allows for Services/SCUs to customise their response and describe all QI Plans in full. Submission of Part B to the NQMC is optional.

Where there is overlap between an existing QI plan and the Response by Service form (BSA005), the Response by Service form can simply refer the reader to the QI plan as its response.

6

APPLYING FOR ACCREDITATION

6.1 INTRODUCTION

This Section summarises the steps for applying for accreditation for Services/ Services and State Coordination Units (SCUs) in each of the following situations:

- new Services;
- new units within accredited Services; and
- re-applying for accreditation for Services and SCUs.

The timeframes given are considered by the National Quality Management Committee (NQMC) to be reasonable and were determined with the goal of supporting SCUs and Services to organise their accreditation activities and submit documentation to the NQMC in a manner most likely to support a successful outcome.

Commencing activities such as organisation of surveys earlier than the timeframes provided is an option Services may 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.

6.2 STEPS FOR A NEW SERVICE

6.2.1 Work with the SCU to become established as a new Service

At least three months prior to a new Service commencing screening, the SCU must notify the NQMC using a notification of commencement form.

Where appropriate, the SCU ensures that a 'National Accreditation Standards Accountability Framework (NAF)' is developed in collaboration with the Service to confirm for which of the NAS measures the SCU and/or Service are responsible and accountable (see Section 2.6). The NAF will be considered by the NQMC when assessing performance against NAS Measures.

The SCU will arrange a pre-commencement survey which may include members from the SCU and SQC internal to the jurisdiction to ensure all necessary requirements are complied with. This report will outline whether the Service is satisfactory or not in demonstrating its capacity to operate as a BreastScreen Service, and may include recommendations. The SCU will provide a copy of the report to the Service for information and action as required.

The SCU forwards the Notification of Commencement of Service Form and completed pre-commencement survey, with any additional information in support of the Service becoming conditionally accredited, to the NQMC, within 2 weeks of the pre-commencement survey taking place, with its recommendation that the Service be conditionally accredited. The NQMC Secretariat will advise the SCU in writing of conditional accreditation being approved by the NQMC.

6.2.2 Make an application for accreditation

Once a new Service has achieved conditional accreditation, it can choose to apply for full accreditation after two years. This is to ensure that the new Service has sufficient time in which to become established and to collect data to support its application for full accreditation.

6.3 STEPS FOR NEW UNITS WITHIN ACCREDITED SERVICES

6.3.1 Introduction

A new unit within an accredited Service, whether it is mobile or fixed, will be considered for accreditation at the same time as the whole Service. 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. This is because accreditation covers an entire Service, and is based on Service level, rather than unit level data and performance information.

6.3.2 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, either with existing or new personnel;
- the ability of the unit to meet the NAS Measures to the level of the rest of the Service;
- an exception report on any NAS Measures 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 request for the SCU to arrange a pre-commencement visit.

The SCU arranges a pre-commencement survey. If issues are identified during the pre-commencement visit the SCU may choose to undertake a further internal survey once the unit has commenced activities (see Section 5.5). Reports on pre-commencement surveys and internal surveys, if required, will be provided to the Service and included in the

documentation for surveyors at the time of the next accreditation survey.

The responsibility for managing the quality of services both within usual operation and through changes and expansion rests with the Service Director and the SCU.

6.3.3 Discuss self-assessment, the pre-commencement survey report and any issues with the SCU and develop a response if appropriate

In the event that a self-assessment, survey or any review against NAS Measures identifies issues with the unit, the SCU will work with the Service to ensure quality improvement strategies are developed and implemented. The Service Director should develop a response to the report that can be reviewed prior to the application for full accreditation of the Service.

6.3.4 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 survey team must visit a new unit. The pre-commencement and internal survey reports on a new unit will form part of the Service's application for accreditation.

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

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

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

The Service or SCU will complete the Application for Accreditation form (BSA001) and return it to the SCU with copies of supporting documentation within required timeframes for review by the SQC and submission to the survey team.

The accreditation survey will be undertaken in line with the key activities outlined in Section 7.

6.5 EXTENSIONS, UPGRADES AND EARLY APPLICATIONS

The NQMC will consider applications from Services and/or SCUs for:

- Upgrading accreditation status;
- Accreditation in advance of scheduled expiry date; and
- Extensions to accreditation periods.

For all applications under this Section:

- The Service and/or SCU must provide a notice of intention to the NQMC at least 3 months in advance of the meeting to which the proposed application would be submitted. This notice should be submitted through the NQMC Secretariat.
- A Service should develop applications in conjunction with its SCU.
- Where the accreditation has been allowed to lapse, the NQMC will not consider any application under this Section (see Section 6.7).
- The NQMC will consider the potential impact on the National Survey Plan of applications under this Section.

6.5.1 Upgrading accreditation status

Services and/or SCUs may apply for an upgrade to their accreditation status at any time after 2 years from the original accreditation decision.

As part of the application for upgrade:

- Information should be provided about how the Service and/or SCU has addressed identified QI issues. Data from the most recent 12-month period must also be provided at this time.
- The Service and/or SCU will be required to undertake an interim survey (see Section 5.3) unless the NQMC determines otherwise on the basis of evidence provided in the notice of intention.

6.5.2 Early applications

The NQMC will consider applications no more than 6 months in advance of the scheduled expiry date.

The notice of intention should include information as to why the Service and/or SCU is seeking to submit an application for accreditation in advance of the scheduled expiry date.

If the NQMC agrees to consider the application on the proposed new date, the Service and/or SCU should submit an application in accordance with the standard process (see Section 6.4).

The new accreditation period will commence from the date of the NQMC meeting at which the application for accreditation is considered.

6.5.3 Applications for extensions to an accreditation period

If an extension of accreditation is sought it must be made at least six months prior to the date of the NQMC meeting for the re-application for Service accreditation. A Service should develop a request for extension in conjunction with its SCU.

Only one extension of accreditation is allowed. The NQMC will grant extensions of no

longer than nine months. Extensions will not be granted to Services and/or SCUs with conditional accreditation. Where the accreditation has been allowed to lapse, the NQMC will not consider extensions (see Section 6.7).

Extenuating circumstances will always be considered by the NQMC. Extenuating circumstances include situations that are unavoidable and over which the Service and/or SCU 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 rationale. They should be accompanied by data from the most recent 12 month period. A Service and/or SCU 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.

6.6 CALCULATION OF THE ACCREDITATION PERIOD

6.6.1 For accredited Services and/or SCUs

A new period of accreditation is calculated to commence from the time the current accreditation expires. For example, if a Service was initially accredited until 31 August 2013 and received an extension until 30 November 2013, the period of accreditation would be granted from 30 November 2013.

6.6.2 For new Services or units

New accreditation periods start from the date of the NQMC meeting at which the decision to accredit the Service was made.

The accreditation period for new units will match that of the rest of the Service. A new unit does not need to undergo separate accreditation but will fit into the timeframes for the whole of Service accreditation.

6.6.3 End of the accreditation period

The accreditation period will end on the last day of the month of the fourth anniversary of the granting of the accreditation by the NQMC. For example, if the NQMC granted accreditation at its 23 May 2014 meeting, the accreditation period would end on 31 May 2018.

6.7 LAPSED ACCREDITATION

Accreditation is considered to have lapsed if:

- a re-application for accreditation before the end of the current accreditation period has not been submitted to the NQMC; or

- an extension of the accreditation period has not been requested or granted by the NQMC.

A Service in either of the above situations is categorised as non-accredited. Therefore, to become accredited it will need to apply for conditional accreditation as if it were a new Service.

Where accreditation has lapsed, the NQMC will not consider extensions. It is the responsibility of the SCU to arrange an application be submitted to the NQMC meeting before the accreditation period of the Service/SCU lapses.

6.8 ACCREDITATION AND SIGNIFICANT CHANGES TO A SERVICE

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

- funding arrangements;
- service provider/s;
- structure such as the amalgamation of two Services or realignment of a Service within the organisation;
- physical amenities and/or location; or
- combinations of any of the above or other factors.

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 and the SCU to ensure that the quality of services is maintained throughout periods of change. The Service needs to inform the SCU of all changes above as, or preferably before, they occur.

The SCU will review data and monitor the Service's performance and notify the NQMC in writing of significant changes and, where appropriate, provide available data, including an annual data report and any recommendations made to the Service on performance.

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.

7

ACCREDITATION SURVEY - ACTIVITIES

7.1 PRE-SURVEY ACTIVITIES

7.1.1 Pre-survey activities - National Surveyor

Appointment of a survey team

The National Surveyor appoints survey teams from those included on the surveyor register (see Section 8.5), upon request from the SCU. The National Surveyor will notify the SCU of the nominated surveyors as soon as possible to allow the SCU to arrange and schedule the visit.

The National Surveyor is responsible for ensuring that any potential or perceived conflict of interest with the nominated surveyors is mitigated appropriately (see Section 8.2.2).

The SCU is responsible for payment of allowances and honorariums for eligible surveyors and Data Assessors in accordance with the requirements described in [Attachment 4](#).

Composition of BreastScreen Australia Accreditation Survey Teams

The survey team is required to have:

- no more than one member of the team assessing for the first time;
- no member of the team from the jurisdiction being assessed (unless in exceptional cases approved by the National Quality Management Committee (NQMC) Chair); and
- the National Surveyor chair the survey team.

In addition to the Data Assessor, the accreditation survey team should have a minimum of three individuals. The team should be expertise based, with corporate and clinical governance skills, specific to the needs of the specific Service survey.

In addition to the Data Assessor, the Service survey team should include at a minimum:

- National Surveyor;
- Service Director or Program Manager
- a minimum of one clinician, identified by the Service/SCU or NQMC who will be determined on a case by case basis according to any issues identified by the Service and/or SCU/NQMC.

Optional members of the survey team may include a health professional with breast cancer

screening expertise such as a breast care nurse, radiologist, radiographer, pathologist, breast physician, surgeon and/or a consumer, as determined by the National Surveyor.

In addition, for multi-service jurisdictions:

- a senior representative from the SCU must be in attendance (or available via tele/video conference) for Service surveys; and
- Surveyors may request to speak with Service Directors via tele/video conference, if required, for SCU surveys.

These additional members are to act as observers only.

As a result of the delineation of responsibilities of Services and SCUs with respect to the accreditation Measures as per the NAS Accountability Framework (NAF), these representatives will be required to answer any questions the survey team may have about the operation of the Service and/or SCU which impact on the performance of the Service and/or SCU being assessed.

The survey team should meet in person or by teleconference before a survey to discuss any issues and receive a briefing from the SCU. If a teleconference is the preferred option, it will be arranged by the National Surveyor in consultation with the SCU to take place once all documentation has been received by the team, preferably, in the week before the visit.

7.1.2 Pre-survey activities - The SCU

Provide material to the survey team members

The SCU must provide each member of the survey team with copies of the accreditation documents no less than three weeks prior to the survey. This is to allow team members sufficient time to examine the forms and supporting material and to decide on any aspects needing further information or follow-up. The documents should include but not be limited to:

- the completed application for accreditation form;
- previous survey report if applicable;
- the last NQMC accreditation and outcome report letters, and any other relevant correspondence from the NQMC;
- interim or internal survey reports if applicable;
- annual data report with responses to unmet measures;
- NAF and Service/SCU QI plan;
- any trend data available;
- relevant correspondence between the SCU and the NQMC during the accreditation period; and

- other relevant documentation.

Accreditation documentation should be marked 'confidential' and transported securely.

Travel and accommodation

The SCU should consult with the surveyors and the Data Assessor to ensure appropriate travel and accommodation arrangements are made in accordance with the requirements described in [Attachment 4](#) of this Handbook.

Prepare program for the survey

A program for the survey must be developed early to ensure availability of appropriate staff at agreed times, and that optimum use is made of limited time. Essential components of the survey program include:

- meetings with the Service Director and other relevant staff;
- Chair of the SQC;
- visits to screening units;
- a meeting for the survey team to plan their activities for the visit;
- a meeting with staff for introductions to be made;
- time for clinicians to meet with clinical specialists; and
- time for the survey team to meet for confidential discussions and work on the survey report towards the end of the visit and before verbal feedback is provided to staff.

For surveys of Services, the SCU works in collaboration with the Service to develop a flexible program for the survey. The survey team can request to change the schedule in consultation with the Service to ensure the aims of the survey are best met.

7.1.3 Pre-survey activities - The Service

Preparation of the Service for accreditation

Prior to the survey the Service must:

- ensure there is a current NAF in place that clearly identifies those accreditation Measures for which they are responsible;
- undertake a self-assessment against the NAS Measures as part of the application for accreditation; and
- ensure that the completed application forms and supporting documentation are submitted to the SCU in the required timeframe.

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 assessment clinics on the days a survey is scheduled. It is highly desirable to schedule an assessment clinic during a survey to allow surveyors observe the operations of the assessment clinic.

If possible, the Service should scale down screening and assessment operations, to allow the survey 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 staff for designated positions for the survey to free up staff time during clinics, allowing key staff to interact with the survey team.

Organise support for the survey team

Surveyors should have access to:

- a room for their exclusive use during the survey;
- a laptop or other computer with the relevant pre-filled electronic templates loaded, and a printer;
- a telephone; and
- refreshments.

7.2 DURING THE SURVEY

The Service Director and other relevant staff will meet with the survey team at the commencement of the survey 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 Measures and decision-making tool, and its quality improvement plan. It may also respond to issues raised in the previous survey report.

The survey team should have access to all relevant Service documentation for their review. This includes images and performance data from each unit, especially trend data where Measures are not met, policies and procedures manuals, quality assurance and professional development and training records.

Information gained during the survey and included in the report will enable the NQMC to be fully informed of all aspects relevant to accreditation of the Service.

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

While there is no specific requirement for client consultation during a survey, client consultation may be undertaken. The survey team will need to attain informed consent and to consider a range of issues such as privacy and appropriateness. It may also be possible to speak to consumers outside of clinic times or to consumer volunteers.

One of the key objectives of the BreastScreen Australia Program is to 'Provide high quality services that are acceptable and appropriate to the needs of the population and equally accessible....' With this in mind, all members of a survey team, including any consumer representative, are encouraged to consider the consumers' perspective when undertaking a survey.

The National Surveyor, as chair of the survey team, will encourage all team members to contribute to every aspect of the survey, and facilitate the survey team to reach a consensus in summing up the survey's findings. The chair will also coordinate the report writing relating to the findings at the survey in consultation with the other survey team members.

It is vital that plenty of time is allowed for the survey team to meet at the beginning and end of the visit to identify issues and areas of outstanding performance for completion of the survey report form.

Each member of the team should sight the final survey report and have time to consider it before they endorse the document. Extra time may be required to finalise the report, it is appropriate for the document to be distributed following the survey to members of the team for signature, with due consideration of confidentiality requirements.

The National Surveyor forwards the report to the State Coordination Unit (SCU) within two weeks of the visit, for provision to the Service (if applicable).

7.3 CLOSING MEETING WITH THE SERVICE/SCU

At the close of the visit, the survey team will meet with Service and/or SCU staff for a debriefing of the survey.

The survey 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 survey, and discuss the process and any highlights and issues. Survey team members may wish to comment on findings that are relevant to their area/s of expertise. The debrief should ensure that the Service has a realistic understanding of the survey team's findings and therefore will not be surprised upon receiving the written report.

Accreditation documentation should be treated with confidentiality at all stages of the process. Information gathered during the survey should not be discussed outside the survey team, apart from reasons relating directly to accreditation. For instance, the SCU could contact the National Surveyor to seek clarification of a matter in the survey report.

Surveyors should keep copies of their notes for six months after a survey in case of an appeal. After that, all documentation created as part of the survey process, including notes of the survey team, should be destroyed. Documentation provided by the Service and/or SCU, such as manuals, organisational structure charts, and reports, should be returned at the end of the survey. Documents should be destroyed if they contain annotations made by

the survey team that could be considered sensitive. Alternatively, such annotations may be removed or obscured before return of the documents. Surveyors may take copies of any necessary documentation in order to finalise the survey report. These documents should be returned to the SCU or destroyed once the report is complete.

7.4 PROVISION OF FEEDBACK FOR SERVICES, STATE COORDINATION UNITS AND SURVEYORS

A number of feedback forms have been developed in order to complete the feedback loop and integrate continuous quality improvement into the accreditation process⁸. These tools will allow surveyors, Services, SCUs and the NQMC to provide constructive feedback on the:

- performance of the survey team and individual surveyors;
- administration and coordination of the survey process; and
- quality of reporting from the survey team in assisting the NQMC's deliberations.

The range of feedback forms is outlined below.

7.4.1 A 'Survey Evaluation Tool' (BSA009)

- This form is to be completed by the Service and/or SCU undergoing accreditation.
- This will enable Services and/or SCUs to provide feedback on the performance of the survey team, including the National Surveyor.
- The feedback will be collected by the NQMC Secretariat. Confidential and de-identified information will be provided to the National Surveyor for provision to individual survey members and the Service and/or SCU.
- Where possible, the completed form should be provided to the NQMC secretariat within 2 weeks of the survey.

7.4.2 A 'Report Evaluation Tool' (BSA008),

- This form is to be completed by an NQMC representative reviewing the survey report.
- This will provide constructive feedback to the National Surveyor and surveyors on the quality of the report in assisting the NQMC's determination regarding the application for accreditation and recommendations for quality improvement.
- The NQMC Secretariat will provide de-identified feedback to the National Surveyor.

⁸ Gail Ward, Report for the BreastScreen Australia National Quality Management Committee, Quality Improvement Recommendations to enhance the Rigour and Robustness of the Site Visit (Survey) Element of the Accreditation System, August 2011.

- Where possible, the completed form should be provided to the NQMC secretariat within 1 week of the next NQMC meeting.

7.4.3 A 'Surveyor Evaluation Tool' (BSA010)

- This form is to be completed by the surveyors conducting the accreditation survey.
- This will enable surveyors to provide constructive feedback to the Service and/or SCU on the administration and coordination of the accreditation process.
- The feedback will be collected by the NQMC Secretariat. Confidential and de-identified information will be provided to the National Surveyor for provision to individual survey members and the Service and/or SCU.
- Where possible, the completed form should be provided to the NQMC secretariat within 2 weeks of the survey.

Following consultations with the National Surveyor and discussions with the NQMC Chair, the implementation of the Surveyor Evaluation Tool has been postponed, pending further consideration of the best means of assessing Surveyor performance.

7.4.4 An 'Accreditation Outcome Letter',

- This form will be used by the NQMC Secretariat to inform the Service and/or SCU, surveyors and State or Territory Department of Health of the NQMC's accreditation decision.

7.5 THE STATE COORDINATION UNIT - ACCREDITATION DOCUMENTATION TO NQMC

The State Coordination Unit (SCU) must check the accreditation submission against the checklist at [Attachment 3](#), prior to forwarding to the National Quality Management Committee (NQMC) Secretariat and the SQC at least two weeks before the NQMC meeting. The SCU may choose to enclose a covering letter, drafted in consultation with the SQC, to accompany the accreditation documentation, however this must not include an assessment of the application, nor a recommendation to the NQMC. Accreditation documentation should be marked 'confidential' and submitted to the NQMC Secretariat securely.

8

SURVEYORS AND DATA ASSESSORS

8.1 ROLES AND RESPONSIBILITIES OF THE NATIONAL SURVEYOR

The National Surveyor function has been established to enhance the national consistency, objectivity and quality of BreastScreen Australia surveys. The BreastScreen Australia National Surveyor will support continuous quality improvement of the Program by providing high quality and centralised coordination, oversight and management of the accreditation survey process for all BreastScreen Australia State Coordination Units (SCUs) and Services.

The National Surveyor is the central point of contact for all issues relating to accreditation surveys. This includes, selecting and appointing all survey teams, chairing all survey teams, managing the recruitment, training and professional development requirements of BreastScreen surveyors and reporting the findings of all BreastScreen surveys to the National Quality Management Committee (NQMC), with support from the SCUs (where appropriate).

The National Surveyor reports to the NQMC Chair and has four key responsibilities as outlined below. Should the National Surveyor function no longer be filled, it is anticipated that the responsibilities of the National Surveyor would be delegated to the NQMC Secretariat and the Chair of the survey team. This would be negotiated in consultation with the NQMC Secretariat and accreditation managers within each jurisdiction.

8.1.1 Planning and Coordination

- Manage the recruitment, orientation, training and performance review of surveyors according to agreed selection criteria.
- Maintain the national register of BreastScreen Australia surveyors and Data Assessors.
- Select survey teams to undertake accreditation surveys (including data governance and management assessments) across BreastScreen Australia Services and SCUs from those included on the register.
- Arrange the pre-survey briefing/teleconference with the survey team.
- Ensure all surveyors and Data Assessors have signed appropriate confidentiality and declaration of interests form, and maintain a copy of the signed forms.
- Work with the NQMC Secretariat and SCUs to maintain the accreditation schedule for all services.

8.1.2 Leading accreditation surveys

- Chair all BreastScreen Australia accreditation surveys, ensuring quality and consistency across survey teams nationally.
- Verify the self-assessment, and evaluate the performance of BreastScreen Australia Services and SCUs against the National Accreditation Standards (NAS), along with the other survey team members.
- Upon appointment to an accreditation task, remind surveyors and Data Assessors of their obligations relating to confidentiality/conflict of interest, and monitor adherence to these provisions throughout the duration of the survey.

8.1.3 Performance appraisal/Review and Training

- Oversee training of BreastScreen Australia surveyors including BreastScreen Service directors, clinicians and consumers.
- Provide feedback to individual surveyors on their performance following accreditation surveys to maintain and improve the quality of accreditation surveys and surveyors.

8.1.4 Reporting and Analysis

- Write the survey report, with input from the survey team, outlining the findings of the accreditation survey and provide the report to the SCU within two weeks of the survey, for provision to the Service (if applicable).
- Attend all NQMC meetings (held quarterly) and report to the NQMC about the outcomes of the accreditation survey for the Service and/or SCU being accredited.
- Assist the NQMC secretariat in analysing information obtained through accreditation surveys to identify trends in performance and service delivery at a service, jurisdiction and national level.
- Provide reports to the NQMC regarding incident analysis and performance trends identified within and across the Program.

The specific activities to be undertaken or coordinated by the National Surveyor will be outlined in a Work Plan that will be:

- developed in consultation with the states and territories;
- submitted to the NQMC for approval; and
- reported against and reviewed at each NQMC meeting.

8.2 COMMITMENT AND RESPONSIBILITIES – SURVEYORS AND DATA ASSESSORS

8.2.1 BreastScreen Australia Surveyor Roles/Responsibilities

BreastScreen Australia surveyors (including Data Assessors) play a major role in monitoring and improving the high quality of the screening services delivered by BreastScreen SCUs and Services.

There are two key functions BreastScreen Australia surveyors are expected to fulfill, including:

- validating the self-assessment of BreastScreen Services and SCUs; and
- providing educative and learning opportunities to facilitate continuous quality improvement for the Service and/or SCU.

Being a surveyor also provides opportunities for personal and professional development.

When undertaking a survey, BreastScreen surveyors are ambassadors for BreastScreen Australia and should uphold the aims of the Program to ensure the delivery of safe, high quality breast screening services.

During the accreditation survey, BreastScreen surveyors may offer respectful and constructive feedback to Service and/or SCU staff to help identify and address issues specific to the Service and/or SCU. This informal, on-site education should assist the Service and/or SCU to anticipate and mitigate future problems and drive continuous quality improvement.

Surveyors also have a responsibility to ensure they maintain and update their skills so they can carry out their role as an effective evaluator and educator. Another role of surveyors is to act as a sounding board and collaborative team member to their colleagues. While individual surveyors may have expertise in a particular area, all surveyors are expected to have a sound understanding of population based screening principles and objectives of the BreastScreen Australia accreditation system. This knowledge will enable surveyors to undertake a high quality evaluation of BreastScreen Australia Services and/or SCUs and to provide constructive feedback to improve quality of service delivery.

8.2.2 BreastScreen Australia Surveyor Commitments

BreastScreen Australia recognises that surveyors are committed to performing their duties to a high standard.

Surveyors should acknowledge their responsibilities to BreastScreen Australia and that their conduct will reflect on BreastScreen Australia. Surveyors should demonstrate this by:

- behaving appropriately, professionally and providing constructive advice;
- being courteous and diplomatic;

- being impartial, fair, objective and accountable;
- updating and maintaining their skills and knowledge of the BreastScreen Australia NAS, accreditation system, screening technologies and equipment, quality improvement activities and other relevant topics up to date;
- acknowledge their responsibilities and abiding by confidentiality requirements, by signing the confidentiality and conflict of interest deed poll (BSA501);
- notifying the National Surveyor of any potential or perceived conflict of interest which include:
 - Relationships with organisations contracted to the Service and/or SCU;
 - Relationships with key people within the Service and/or SCU;
 - Previous or current employment within the jurisdiction, Service and/or SCU;
 - Ethical factors;
 - Any other circumstances which may result in a perceived or actual conflict of interest.
- undertaking all the components of a survey, including reading of documentation and engaging in a preliminary team meeting or teleconference, the actual survey, and any activities to finalise the survey, including completion and sign off of the report and providing feedback to the NQMC if required;
- completing the Surveyor Evaluation Tool (BSA010) and submitting it to the NQMC Secretariat within two weeks of the conclusion of the survey;
- participating in ongoing surveyor training and professional development; and
- maintaining effective lines of communication with the National Surveyor and other survey team members.

8.3 SELECTION CRITERIA AND COMPETENCIES FOR NEW SURVEYORS OR DATA ASSESSORS

The National Surveyor is responsible for developing the selection criteria and competencies for BreastScreen Australia surveyors and Data Assessors. These selection criteria will be made publicly available via the Department of Health's [cancer screening](#) website.

8.4 SURVEYOR AND DATA ASSESSOR APPLICATION PROCESS

Applications to be a BreastScreen surveyor or Data Assessor should be made to the National Surveyor for consideration and approval. The application will provide the information which addresses the selection criteria outlined on the Department of Health's cancer screening website.

The National Surveyor will advise applicants in writing of the outcome of the selection processes and will update the register accordingly.

8.5 REGISTER OF SURVEYORS AND DATA ASSESSORS

Following successful appointment to the position of a surveyor or Data Assessor, the National Surveyor will include the details of the individual on the national register of BreastScreen Australia surveyors and Data Assessors.

The information on the register will allow the National Surveyor to consider the best available mix of skills and experience when assembling a survey team. It will also assist in managing the workloads of appointees, as details of survey history and Data Governance and Management Assessments will be available. The register should contain details of no less than 40 suitably qualified and trained professional surveyors and no less than eight Data Assessors.

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 surveyors and Data Assessors are assigned according to Program requirements. The Program reserves the right to access contact details of surveyors and Data Assessors for purposes relating to the Program, such as to invite people to participate in training or consultative opportunities.

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 surveys or data governance and management assessments over each two year period.

Appointment to the register is for an indefinite period. Should an individual resign from the Program the individual can remain on the register and conduct surveys up to 2 years after leaving the Program. This will be at the discretion of, and require agreement by the Chair of the NQMC. For Data Assessors 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 National Surveyor in writing of their decision.

The NQMC may review the appointment of surveyors and Data Assessors to the register. It has the authority to remove the name and details of a surveyor or Data Assessor from the register for reasons such as unsatisfactory performance, breach of conduct, or at the request of the surveyor or Data Assessor.

8.6 TRAINING

All surveyors, including Data Assessors, must complete the BreastScreen Australia surveyors' training program, and any relevant updates, whether they are experienced surveyors or

new to the role. It is desirable that SQC and SCU members who undertake interim surveys also undertake this training.

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

It is recommended that jurisdictions consider the role of observers on surveys. For instance, observation of a survey 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 survey team. The same confidentiality provisions affecting the rest of the team apply to observers. Agreement by all members of the survey team is required before an observer is given approval to attend.

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

Surveyor training is an important part of the accreditation process for BreastScreen Australia. Regular review and updates to the training program are important to ensure knowledge and skill levels are maintained and consistency between surveyors is evident.

9

MANAGING ADVERSE EVENTS AND GAPS IN PERFORMANCE

9.1 MANAGING ADVERSE EVENTS

BreastScreen Australia is committed to delivering high quality breast cancer screening services within a continuous quality improvement framework. Aligned with this commitment is a need to ensure adverse events, which occur within the Program are identified, addressed and learned from, to mitigate the risk of such events recurring in the future. Protocol 7.13 requires all BreastScreen Services and/or State Coordination Units (SCUs) to implement, and continually evaluate, an incident management process that includes the identification, reporting, investigation, analysis, action, feedback and open disclosure of incidents that occur in the Service and/or SCU.

9.2 THE ROLE OF THE NATIONAL QUALITY MANAGEMENT COMMITTEE (NQMC) IN MANAGING ADVERSE EVENTS

The NQMC will use the information provided by Services and/or SCUs to identify issues which need to be addressed at a national level in order to ensure the continued safety and quality and improvement of BreastScreen services. This information will assist the NQMC develop national quality improvement strategies to minimise recurrence of such events across BreastScreen Australia. If necessary, the outcomes and lessons learned from specific events may need to be reported to the Standing Committee on Screening. This will be determined on a case by case basis.

The information provided to the NQMC about adverse events *will not* impact on the accreditation status of any Service and/or SCU, unless the NQMC considers that the safety of BreastScreen clients is at risk. Non-reporting of identified events may impact on the accreditation rating of the Service and/or SCU by the NQMC.

9.3 INCIDENT MANAGEMENT PROCESS

Each state and territory government has an incident management policy for reporting and managing adverse events that is applicable to all health services within that jurisdiction including BreastScreen Services and/or SCUs. This policy should include a series of actions, which need to take place to ensure the incident is managed effectively. These actions may vary between jurisdictions but are likely to include the following steps:

- Identification
- Initial action
- Notification
- Prioritisation
- Investigation
- Analysis
- Improvement action
- Feedback.

Each BreastScreen Service and SCU should follow their respective jurisdictional incident management process when an incident is identified within the Service and/or SCU.

Incidents identified within the Service and/or SCU should be:

- classified according to Table 3;
- addressed using the relevant jurisdictional incident management process; and
- reported to the NQMC and/or
- advised to other BreastScreen Australia Services who may need to be informed using Table 4 (action required according to incident).

9.4 INCIDENT CLASSIFICATION

BreastScreen Australia uses a three level system to classify incidents, which may occur within Services and/or SCUs. This classification is described overleaf for both clinical incidents and corporate/system incidents, in order of severity

Table 3: Classifying adverse events

	Level 1	Level 2	Level 3
Clinical Incidents	<p>Unexpected death of a patient differing from the immediate expected outcome and where it is suspected there is a relationship between the service provided and the patient death</p> <p>OR</p> <p>Permanent loss of function of a patient (sensory, motor, physiologic or psychological) unrelated to the natural course of the illness and differing from the expected outcome of patient management</p> <p>OR</p> <p>National Sentinel Event (refer table overleaf)</p> <p>OR</p> <p>A major concern or event which has the potential to undermine public confidence in BreastScreen Services</p> <p>OR</p> <p>A major concern or event which impacts on a significant number of women attending BreastScreen Services</p>	<p>Permanent reduction or temporary loss of bodily functioning of a patient (sensory, motor, physiologic, or psychological) unrelated to the natural course of the illness and differing from the expected outcome of patient management</p> <p>OR</p> <p>Significant disfigurement as a result of the incident</p> <p>OR</p> <p>Significant risk to a patient resulting from</p> <ul style="list-style-type: none"> • being absent against medical advice • threatened or actual physical or verbal abuse <p>OR</p> <p>Increased surgical intervention due to consequences of care given or not given</p>	<p>Minor or no injury. No increased level of care or length of stay</p>
Corporate/System Incidents	<p>Complete loss of service or output</p> <p>OR</p> <p>A major concern or event which has the potential to undermine public confidence in BreastScreen Services</p> <p>OR</p> <p>A major concern or event which impacts on a significant number of women attending BreastScreen Services</p>	<p>Major loss of agency / service to users</p> <p>OR</p> <p>Major disruption to users</p>	<p>Reduced efficiency or disruption to agency working</p> <p>OR</p> <p>Incident resulting in no loss of service</p>

9.5 NATIONAL SENTINEL EVENTS

National sentinel events are defined by the Australian Commission on Safety and Quality in Health Care and must be reported and investigated as Level 1 incidents.

National Sentinel Events are reported in the Australian Government Productivity Commission's Report on Government Services and the Australian Commission on Safety and Quality in Healthcare's annual Windows into Safety and Quality in Healthcare Report. A National Sentinel Event includes the following:

- procedures involving the wrong patient or body part resulting in death or major permanent loss of function;
- suspected suicide in hospital;
- retained instruments or other unintended material after surgery requiring re-operation or further surgical procedure;
- medication error involving the death of a patient reasonably believed to be due to incorrect administration of drugs;
- intravascular gas embolism resulting in death or neurological damage;
- haemolytic blood transfusion reaction resulting from ABO incompatibility;
- maternal death or serious morbidity associated with labour and delivery; and
- infant discharged to the wrong family

While sentinel events are more relevant to, and more likely to occur within the acute health sector, should a sentinel event occur within a BreastScreen Service and/or SCU (e.g. death of a patient as a result of a fall within the service), it must be reported and addressed in line with jurisdictional protocols. The final report detailing the findings and outcome of the investigations must be provided to the NQMC.

9.6 ACTION

Each BreastScreen Service and/or SCU must undertake actions to address any incident and mitigate the risk of it occurring in the future. The remedial actions required and timeframes for completion will be dependent upon the classification given to the incident and will be determined through the 'investigation' phase of the jurisdiction's incident management process.

All incidents should be investigated and actioned, regardless of whether the incident is classified as a level 1, 2 or 3. However, only level 1 incidents need to be reported nationally to the NQMC.

The table below outlines the expectations of BreastScreen Australia Services and SCUs in relation to addressing and reporting incidents that occur within the Program.

Table 4: Reporting requirements for adverse events

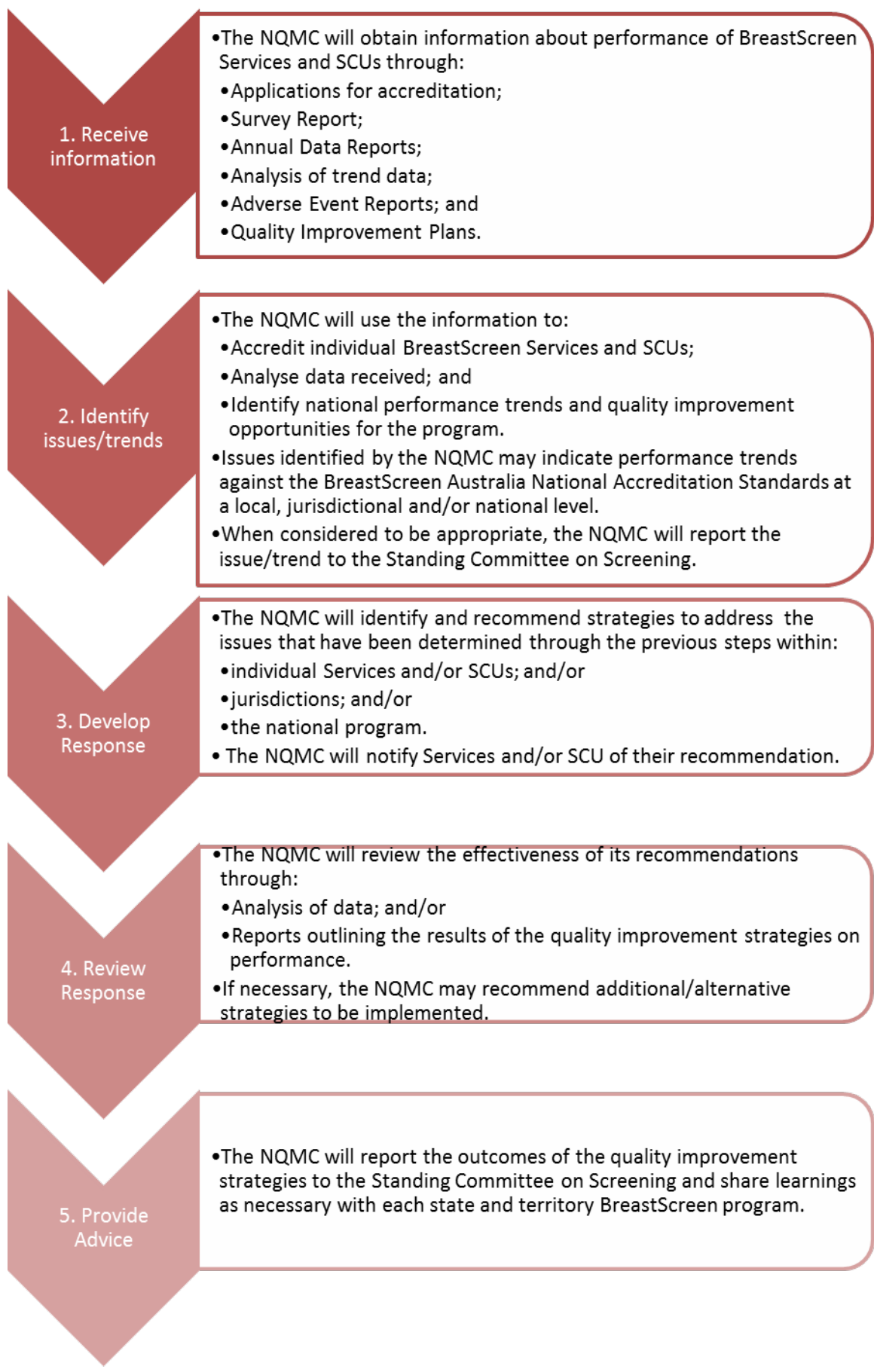
	Level 1	Level 2	Level 3
<p>Action Required – applicable to both clinical and corporate incidents</p>	<p>An investigation that includes an examination of root causes to be undertaken in accordance with state or territory policies and protocols.</p> <p>The jurisdictional SCU, State Quality Committee (SQC) and Department of Health must be notified of the incident and the commencement and outcome of investigations.</p> <p>The final report, which details the findings and outcomes of investigations must be provided to the NQMC.</p>	<p>A thorough investigation to be undertaken in accordance with state or territory policies and protocols.</p> <p>The jurisdictional SCU and SQC must be notified of the incident and the commencement and outcome of investigations.</p> <p>Report to the NQMC and/or other jurisdictions if the adverse event has or potentially has national risks or implications.</p>	<p>Incidents that are similar in nature should be aggregated by the Service and/or SCU and investigated in groups to determine and address the cause of the incident.</p>

Attachment 1: BreastScreen Australia National Quality Improvement Framework

The purpose of the BreastScreen Australia National Quality Improvement Framework is to outline the process through which quality issues identified within BreastScreen Australia are managed to drive continuous quality improvement at a national, state and service level.

The BreastScreen Australia National Quality Management Committee (NQMC) is responsible for monitoring the quality of services delivered by BreastScreen Australia. This framework describes five steps for how the NQMC will use the information it receives from BreastScreen Screening and Assessment Services (Services) and State Coordination Units (SCUs), and jurisdictional State Quality Committee (SQC)'s and survey reports to optimise performance of the national program. It is expected that each SQC develops its own Quality Improvement Framework which is informed by and aligns with this five-step approach.⁹

⁹ At the conclusion of step 5, the process re-commences, demonstrating a continuous cycle of quality improvement within the Program.



Attachment 2: BreastScreen Australia National Accreditation Standards and Risk Category Grouping

Standard 1	Risk Category Grouping		
	Level 1	Level 2	Level 3
Access and Participation		1.1.1	1.2.2
		1.1.2	
		1.1.3	
		1.2.1	

Standard 2	Risk Category Grouping		
	Level 1	Level 2	Level 3
Cancer Detection	2.1.1	2.1.4	2.2.3
		2.1.5	
		2.1.6	
	2.1.2	2.2.1	2.5.1
	2.1.3	2.2.2	2.5.2
		2.2.4	
		2.3.1	2.6.2
		2.3.2	
		2.4.1	
		2.6.1	
		2.6.3	
		2.6.4	
		2.6.5	
		2.6.6	
		2.6.7	

Standard 3	Risk Category Grouping		
Assessment	Level 1	Level 2	Level 3
	3.1.4	3.1.1	3.1.6
	3.1.5	3.1.2	
	3.1.7	3.1.3	
	3.1.8		

Standard 4	Risk Category Grouping		
Timeliness	Level 1	Level 2	Level 3
	4.2.1	4.1.1	
		4.1.2	
		4.2.2	
		4.2.3	
		4.2.4	
		4.2.5	
		4.2.6	

Standard 5	Risk Category Grouping		
Data Management and Information Systems	Level 1	Level 2	Level 3
		5.1.1	5.1.2

Attachment 3: National Quality Management Committee Checklist

When an accreditation application or annual data report (ADR) is received for review at a National Quality Management Committee (NQMC) meeting, the NQMC Secretariat checks for completeness against the following **minimum** document requirements.

Outside of this check, the completeness of the content of these documents is the responsibility of State Coordination Unit (SCU), hence it is not necessary for the NQMC Secretariat to check that the content/data provided meets specific requirements outlined in the National Accreditation Handbook and National Accreditation Standards (NAS) documents.

Accreditation Applications

- Signed covering letter from SCU (optional)
- BSA001 Application for Accreditation
- BSA003 NAS Accountability Framework for multi-service jurisdictions (only required the individual Service NAF differs from the standard jurisdictional NAF)
- BSA004 Data Report
- BSA101 Survey Report and (where appropriate):
 - BSA302 DGMA Self-Assessment
 - BSA303 DGMA Data Assessor Report
 - BSA304 Response by Service/SCU to Data Assessor Report
- BSA005 Service Response
- BSA006 Quality Improvement Plan Part A (Part B optional)
- Interim or internal survey reports (relevant to the reporting period)
- 5-year Funnel Plots for Cancer Detection NAS 2.1.1; 2.1.2; 2.1.3; 2.2.1; 2.2.2

- NAS 4.2.1 (a) monthly data; and, if unmet,
NAS 4.2.1 (b) number of days to meet standard

Annual Data Reports

- Signed covering letter from SCU (optional)
- BSA003 NAS Accountability Framework for multi-service jurisdictions (only required the individual Service NAF differs from the standard jurisdictional NAF)
- BSA004 Data Report
- BSA005 Service Response
- BSA006 Quality Improvement Plan Part A (Part B optional)
- Interim or internal survey reports (relevant to the reporting period)
- 5-year Funnel Plots for Cancer Detection NAS 2.1.1; 2.1.2; 2.1.3; 2.2.1; 2.2.2
- NAS 4.2.1 (a) monthly data; and, if unmet,
NAS 4.2.1 (b) number of days to meet standard

Attachment 4: Payment and Travel Requirements for Surveyors and Data Assessors

This Section outlines the processes applicable to the Surveyors and Data Assessors for the payment and reimbursement for services to BreastScreen Australia. It is critical to the ongoing success of the BreastScreen Australia accreditation system to adequately reimburse and remunerate Survey Team members for their valuable contribution to Program quality.

States and Territories need to comply with the relevant remuneration rates and travel allowances using the most up-to-date Australian Government Remuneration Tribunal determinations to ensure all Surveyors and Data Assessors are paid consistently across all jurisdictions.

REMUNERATION

The jurisdiction/Service will pay Surveyors and Data Assessors according to the most up to date information in the relevant Remuneration Tribunal Determinations.

The relevant remuneration determinations are:

- *Remuneration Tribunal (Remuneration and Allowances for Holders of Part-time Public Office) Determination 2019* (or most recent update) and;
- *Remuneration Tribunal (Official Travel) Determination 2019* (or most recent update).

Both may be found on the [Part-Time Offices page of the Remuneration Tribunal Website](#).

Eligibility for payment of a daily fee

Surveyors and Data Assessors are eligible for payment of a daily fee unless they are employed full-time by BreastScreen or another Government agency. Those working part-time for BreastScreen or another Government agency may be eligible for a daily fee payment if all or part of the survey takes place on a day(s) that they are not employed by BreastScreen or another Government agency. Contractors are eligible for payment of the daily fee. The National Surveyor is not eligible for payment of the daily fee.

PAYMENTS

The jurisdiction/Service undergoing accreditation is responsible for paying the following costs for Surveyors and Data Assessors:

- daily fee (eligible Surveyors and Data Assessors only – see eligibility criteria below);
- honorarium;

- accommodation;
- airfares;
- taxis, parking and airport transfers; and
- meals and incidentals (according to whether the Surveyor or Data Assessor is claiming the daily fee).

The jurisdiction/Service is also responsible for:

- informing Surveyors and Data Assessors in writing of the arrangements for payments and reimbursements before the survey commences; and
- making timely payments 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.

Payment of a daily fee

The full daily fee should be paid for any survey lasting more than three hours, while a half day rate should be paid for any survey lasting three hours or less.

- Surveyors and Data Assessors will be paid according to the current Member rate listed in the Remuneration Tribunal Determination 2019 Table 4A for Professional Services Review – Committees (or most recent update).
- The National Surveyor is not paid a daily fee but will have expenses remunerated as per the Remuneration Tribunal (Official Travel) Determination 2019 (or most recent update).
- All Surveyors and Data Assessors are to be paid at the Tier 1 rate.

Honorarium

The honorarium is intended to cover time spent preparing for a survey including pre-survey reading, teleconference and completion of the survey report.

The jurisdiction/Service will pay Surveyors and Data Assessors the same honorarium payment, which is to be paid at the rate of two days fee as specified in the Remuneration Tribunal Determination Table 4A for Professional Services Review – Committees (or most recent update).

The National Surveyor is not paid an honorarium.

Accommodation

All accommodation will be booked and paid for by the jurisdiction/Service according to the Remuneration Tribunal (Official Travel) Determination 2019. All Surveyors and Data Assessors will be booked into accommodation that has a rating of no less than three stars. Each Surveyor and Data Assessor must have their own room. Surveyors and Data Assessors

are to be paid at the Tier 1 rate.

Airfares

An economy class airfare (flexible preferred) will be booked and paid for all Surveyors and Data Assessors by the jurisdiction/Service.

Taxis, parking and airport transfers

The cost of taxis, parking and transfers are not covered by the daily fee and will be paid by the jurisdiction/Service directly.

Meals and incidentals

The daily fee claimed by eligible Surveyors and Data Assessors is inclusive of meals and incidentals allowances.

Surveyors and Data Assessors who are not eligible to claim the daily fee, including the National Surveyor, will have meals and incidentals (other than those that are supplied by the Service) paid at the rates set out in the Remuneration Tribunal (Official Travel) Determination 2019 Tables 6C or 6D (or most recent update) according to the location of the survey being undertaken.

Attachment 5: The Use of Confidence Intervals in NQMC Decision-Making

When appraising the performance measures of any screening service it's important to acknowledge all measurements of performance are in fact a combination of underlying performance as well as an element of chance.

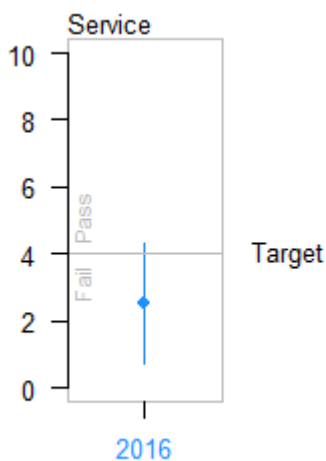
In smaller samples chance is an increasingly large component; in these cases it is difficult to definitively elucidate underlying performance from chance.

Statistical tools such as 95% confidence intervals (95% CIs), aggregated analysis and the small numbers index are helpful in this situation.

Using confidence intervals

It is important to understand the correct use and limitations of 95% CIs in NQMC decision-making. Consider the result outlined in Figure 1. Ostensibly the observed result (dot) is a fail however the 95% CI (vertical line) includes the target result (grey line) and extends into the pass region.

Figure 1: Result for 2016



Two possible interpretations are:

- the observed result indicates unsatisfactory performance
- the observed result indicates a combination of satisfactory performance and bad luck.

However, we cannot discern which of the above is correct – that is, we remain in a state of ignorance. The 95% CI helps protect against reflexively concluding performance is

unsatisfactory, but it does not automatically confer satisfactory performance.

It is neither useful nor correct to interpret this outcome as *“the 95%CI contains the target therefore we are obliged to accept performance is satisfactory and all is well”*. While the 95%CI is comforting information and indicates there is a possibility that the performance may in fact be satisfactory, some doubt remains. More discussion, debate and ancillary evidence is required before a firm conclusion can be reached on the performance outcome and a subsequent decision made.

If the position is taken that the 95%CI's coverage of the target is considered entirely sufficient to warrant accreditation then this raises the prospect that accreditation decisions could be determined solely by a computer with no need to assemble the varied domain experts from around the country. Conversely if 95%CI coverage of the target is considered necessary but insufficient to warrant accreditation this raises the disconcerting possibility that different decisions could be made by different individuals and committees from the exact same set of results. Hence, there is a need for decision-making practice that ensures consistent and logical decisions when considering performance that is clouded by chance.

Confidence intervals and decision-making

Research scientists often rely on 95%CI's to estimate quantities and make conclusions based on their data. Members of the NQMC do not have the luxury of conjecture and conclusions alone, they are charged with the additional step of making decisions based on their conclusions. This additional (and difficult) step requires additional information.

A principled decision-making process takes into account the costs and benefits associated with the decision. The decision maker faces two potential errors:

- false positive errors (deciding there is a problem when there is none); and
- false negative errors (deciding there is no problem when there is one).

These errors and their associated costs are known to statisticians and decision analysts as loss functions. In addition to the likelihood (conveyed by result and its 95%CI) the additional layer (and complexity) of a loss function is required.

As an example, in Australia an aggressive approach is often taken regarding the excision of suspected melanoma lesions; this reflects the relatively minor inconvenience of an unnecessary punch biopsy (in the case of a false positive) and the serious implications of ignoring an invasive melanoma (in the case of a false negative). This clinical decision process is informed by the loss function in addition to the underlying likelihood.

There is a regrettably common practice of well-intentioned researchers relying solely on the likelihood tools that have worked well in their research careers (such as 95%CI's and statistical significance) to make decisions while ignoring the attendant costs and benefits of their decision (the loss function). It is a mistake to think all the necessary information is contained in the 95% confidence interval. A 95%CI improves and informs the decision-

making process but it is not *the* decision-making process.

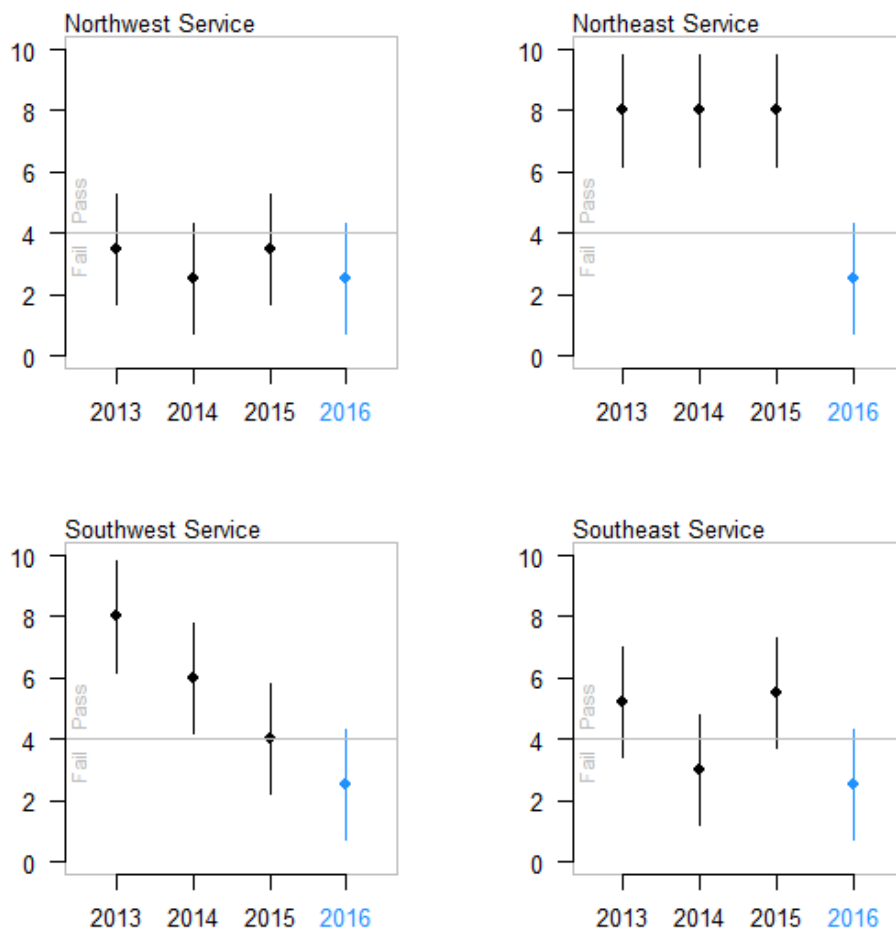
Every (rational) decision we make as humans is based on a combination of loss and likelihood. Similarly, in making an accreditation decision the NQMC has to consider the potential errors (and costs) of their decision.

- A false positive (deciding performance is not satisfactory when in fact it is) results in costs for the service/SCU in terms of an unwelcome additional administrative burden, a distraction from core tasks, and potential lowering of staff morale, etc.
- A false negative (deciding performance is satisfactory when in fact it is not) would mean these costs would be borne by women using the screening service in future years – a potential public health issue.

Quantifying and balancing these costs and benefits is difficult and often subjective (and thus contentious). It often requires input, discussion and agreement from different members of the committee. Decision-makers in the NQMC should clearly document their reasoning and sources of ancillary information when making contentious decisions.

Consider Figure 2 (below) showing data from 4 screening services that have an identical result for 2016 (2.2) and 95% CIs (0.2 to 4.2)

Figure 2: Results 2013-16 for 4 screening services



Decision-making wholly reliant on the 2016 95%CI's ignoring all other sources of information would automatically yield the same decision for each of the services. Data from previous years is sometimes informative.

Previous data indicate performance of the Northwest service is stable/stationary and has consistently failed to meet the standard. Northeast service performance has undergone a recent dramatic deterioration in performance (known as "*a shift*"). Southwest service shows evidence of a consistent decline in performance. For the Southeast the available data do not offer a clear-cut insight into past or present performance, an aggregated result over the 4 year period may be useful.

Along with previous data, useful additional information about a service might include: staff turnover, track record in addressing past issues, a poor/successful site visit, opening of a new facility or a change in management, etc. A principled decision maker may wish to gather, highlight and discuss additional information with the committee and incorporate it into the committee's decision along with balancing the risks and benefits to women and to the screening service in question. This practice may result in a fail for Southwest service and a pass for Southeast in spite of their shared 2016 result.

The small numbers index

As mentioned previously, in smaller samples chance plays an increasingly large role, this uncertainty is reflected by ever widening confidence intervals. In some situations, the available 95%CI's are so wide they resist meaningful interpretation.

An additional supplement available to NQMC members is the small numbers index (SNI). This index uses a statistical technique to aggregate scores from within a group of standards. The result is a single number with an accompanying interpretation. An SNI score is not an absolute indicator of performance – it should be thought of as a guide to determining if a Service's performance warrants further scrutiny.

Attachment 6: NQMC Membership Rotation Policy

The BreastScreen Australia National Quality Management Committee (NQMC) membership rotation strategy has been developed to ensure both continuity and renewal in a structured rotation.

Purpose

The Accreditation Handbook (p.27) states that *“members will be appointed for an initial term of up to three years, with no member serving more than two consecutive terms”*.

The NQMC membership rotation strategy operationalises the Handbook’s requirements in a practical and predictable manner.

Structured rotation

The NQMC membership rotation strategy involves a structured system of renewal¹⁰ based on an annual review. Of the 12 NQMC member roles, there are 9 for whom this strategy applies (excluding the Chair, State Quality Committee Chair member and Commonwealth member roles, where separate appointment processes apply).

Commencing in August 2018, the structured rotation strategy is as follows:

- Each year, three NQMC member roles and three Proxy member roles will be renewed.
 - Over three years, this will facilitate the renewal of the 9 NQMC member roles for which this strategy applies.
 - The three-year member terms will be aligned with this role renewal schedule (note that persons eligible to serve two consecutive terms).
 - Persons who are nominated for a role mid-term will serve the remainder of that term and then may nominate to serve an additional full term.
- Persons in Proxy member roles are to be offered the equivalent vacant member role in the first instance. If the Proxy member declines, the vacancy is to be opened to wider nomination.

¹⁰ For the purposes of this document, the “renewal” of NQMC roles refers to a rotation point with either:

- The current member choosing to continue in a second term: or
- A new person being sought to fill the role.

The rotation schedule commencing in August 2018 is described in Table 1 and Table 2. Once a full rotation schedule is complete, the next cycle will commence.

Table 1 –Schedule of role renewals, commencing 2018

Renewal group	2018	2019	2020	2021	2022	2023	2024	2025	2026
Group A		3 year term			3 year term				
Group B		3 year term			3 year term				
Group C			3 year term			3 year term			

Table 2 –Role renewal groups

Renewal group	Member roles	Proxy member roles
Group A	Jurisdictional Appointed Member Pathologist Member Consumer Advocate Member	Radiologist Proxy Member Epidemiologist Proxy Member Patient Safety and Quality Representative Proxy Member
Group B	Surgeon Member Radiographer Member Data Manager Member	Jurisdictional Appointed Proxy Member Pathologist Proxy Member Consumer Advocate Proxy Member
Group C	Radiologist Member Epidemiologist Member Patient Safety and Quality Representative Member	Surgeon Proxy Member Radiographer Proxy Member Data Manager Proxy Member

Please note that:

- The rotation schedule of Proxy members has been developed to be off-set to the member roles by one year, to reduce risk of both member and Proxy member retiring together.
- The schedule has been developed to stagger the rotation of clinical members.

Transition arrangements

In order to establish a smooth and orderly transition, the three-year terms that current NQMC members are serving need to be aligned with the rotation schedule.

Given the current common commencement date of 2015, this requires adjustments to the length of affected members' current terms, as follows:

- Those members whose roles are to be renewed in 2019 will serve a 4-year initial term;

and

- Those members whose roles are to be renewed in 2020 will serve a 5-year initial term.

All current NQMC members are considered to be serving their first term and will be eligible to serve a second term (commencing in 2018, 2019 or 2020 as indicated in Table 1).

Attachment 7: Revised Approach to Accreditation Decision Making

The NQMC agreed at its 5 March 2021 meeting that due to the impact on the BSA Program of the COVID pandemic, the following accreditation decision-making process would apply until further notice. This revised process replaces the Decision Tool arrangements outlined in Section 3.3 of the Handbook.

1. The use of the Decision Tool in accreditation decision-making be discontinued until further notice.
2. The outputs of the Decision Tool will continue to be monitored (but not considered during decision-making) to determine their value in indicating the collective effect of COVID and other factors on Services/SCUs and in order to assess the impact of COVID on the tool's functionality.
3. During the COVID19 pandemic and recovery period Service/SCU performance against the following NAS measures be monitored in ADR's and accreditation applications:

a) NAS level 2 access and participation benchmark measures:

1.1.1(b)	Participation 50-69 last 24 months ($\geq 70\%$)
1.1.2(b)	Rescreen R1 50-67 in 27 months ($\geq 75\%$)
1.1.3(b)	Rescreen R2+ 50-67 in 27 months ($> 90\%$)

b) NAS level 1 benchmark measures:

2.1.1(b)	Cancer invasive R1 50-69 ($\geq 50/10k$)
2.1.2(b)	Cancer invasive R2+ 50-69 ($\geq 35/10k$)
2.1.3(c)	Cancer small 50-69 ($\geq 25/10K$)
3.1.4	Open biopsies benign R1 ($\leq 0.35\%$)
3.1.5	Open biopsies benign R2+ ($\leq 0.16\%$)
3.1.7	Lesions identified first excision ($\geq 95\%$)
3.1.8(a)	Diagnosis without excision ($\geq 85\%$)
4.2.1(a)	Time to assessment 28 days ($\geq 90\%$)

c) NAS level 2 cancer detection benchmark measures:

2.6.3(b)	Recall R1 50-69 ($< 10\%$)
2.6.4(b)	Recall R2+ 50-69 ($< 5\%$)

4. The NQMC will closely consider the information provided by Services/SCUs in the

Accreditation Data Contextual Reporting Framework that accompanies each accreditation application or ADR and explicitly take that information into account in accreditation decision-making.

5. During the COVID19 pandemic and recovery period, accreditation decisions will be made on the following basis:

- a) Acceptable performance against the following eight NAS level 1 benchmark measures:

2.1.1(b)	Cancer invasive R1 50-69 ($\geq 50/10k$)
2.1.2(b)	Cancer invasive R2+ 50-69 ($\geq 35/10k$)
2.1.3(c)	Cancer small 50-69 ($\geq 25/10K$)
3.1.4	Open biopsies benign R1 ($\leq 0.35\%$)
3.1.5	Open biopsies benign R2+ ($\leq 0.16\%$)
3.1.7	Lesions identified first excision ($\geq 95\%$)
3.1.8(a)	Diagnosis without excision ($\geq 85\%$)
4.2.1(a)	Time to assessment 28 days ($\geq 90\%$)

- b) Acceptable performance against the following two NAS level 2 cancer detection benchmark measures:

2.6.3(b)	Recall R1 50-69 ($< 10\%$)
2.6.4(b)	Recall R2+ 50-69 ($< 5\%$)

- c) Explicit consideration of the accreditation data contextual reporting framework
- d) A consensus of the opinion of clinical and other experts of the NQMC based on the evidence provided, as to whether the Service/SCU is able to take women undertaking a screening mammogram safely through the clinical pathway to a diagnosis and deliver services safely to women who participate in the program.

6. During the COVID19 pandemic and recovery period, Services/SCUs will be awarded one of two categories of accreditation:

- a) Accreditation; or
- b) Accreditation with conditions.

'Accreditation with conditions' describes the outcome(s) that the Service/SCU must achieve in order for the condition to be lifted – it does not specify how or by what means the Service/SCU satisfies the condition(s) under which the accreditation is awarded.

7. That where *'accreditation with conditions'* is awarded, the Service/SCU is required to meet the condition(s) within the specified timeframe.

The timeframe within which the condition(s) must be met will vary according to the clinical nature of the unmet measure(s) and the time within which it could reasonably be expected to be satisfied, particularly during pandemic conditions.