



Royal Australian College of General Practitioners

**Response by the Royal Australian College
of General Practitioners
to the**

**Australian Commission on Safety and
Quality in Health Care
Discussion Paper – National Safety and
Quality Accreditation Standards**

31 March 2007

Executive Summary

The Royal Australian College of General Practitioners (RACGP) is pleased to have the opportunity to respond to the Australian Commission on Safety and Quality in Health Care (ACSQHC) Discussion Paper – National Safety and Quality Accreditation Standards.

The RACGP is responsible for maintaining standards for quality clinical practice, education and training, and research in Australian general practice. It has the largest general practitioner membership of any medical organisation in Australia. The RACGP National Rural Faculty, representing more than 4,500 members, has the largest rural general practitioner membership of any medical organisation in Australia. The RACGP has developed standards for general practices (the standards for the structure and organisation of practices). This work extends over twelve years.

The RACGP believes that an important precursor to a nationally agreed accreditation framework will be agreement on a national framework for the setting of standards.

The RACGP strongly supports the standards setting role of specialist medical colleges, and other professional organisations. The RACGP recommends that the ACSQHC consider ways in which the roles of governmental and quasi-governmental bodies that also set 'standards' can be integrated with the role of specialist medical colleges.

To focus on standards only, or principally, as an underpinning of accreditation is to diminish the fundamental importance of self-improvement. The RACGP argues strongly for an overt recognition of, and support for, the professional role of standards and quality improvement beyond the seeking of accreditation.

The RACGP's view is that initiatives that cross the specialist medical colleges are central to the coordination and harmonisation of standards. The RACGP recommends that the ACSQHC facilitate discussion about the theoretical and conceptual underpinnings of standards amongst those who develop them for Australian healthcare settings as an early step in this process.

The RACGP ensures that its standards are appropriate by consulting general practice and its stakeholders during the development of its standards, pilot testing the standards, and monitoring feedback on the standards following their implementation. It has taken a relatively pragmatic approach, as it believes that the utility of standards is in their day-to-day application in the workplace.

The RACGP supports standardisation of language and definitions where this is important to national strategies for reporting and research, and recognises that the historical use of terms, and the different settings in which standards are applied will be barriers to achieving standardisation.

Versions of the standards used by the profession, and against which settings are accredited, should be readily available to stakeholders.

The RACGP suggests that good will, a framework that addresses accountabilities and roles, and adequate funding are needed to achieve mutual recognition of standards and accreditation.

The RACGP proposes that the following elements are necessary for the detection of poor performance – well written standards with 'good' indicators; effective surveyor training; qualified privilege; and mechanisms for feedback from other organisations e.g. Medical Boards, health complaints commissions.

Appropriate, regular reports need to be made to consumers, especially where qualified privilege is granted. However any data used for comparison must be risk-adjusted, and a process to support data interpretation put in place. The RACGP's position is that it is appropriate for consumers to be able to know whether or not a health service is accredited, and against which standards, the date of next review,

and the place where they can lodge a complaint if they believe the service does not meet the standards against which it is accredited.

Reporting also needs to occur to professional bodies in order to ensure that lapses in quality that are amenable to improved training, for example, are identified and acted upon.

The RACGP supports an escalated response, based on the principles of natural justice, where there is a failure in the system of care.

The RACGP recommends that consideration be given to the advantages and disadvantages of the models for the governance of accreditation that exist in Australia, and some consistency be sought. The RACGP supports the involvement of consumers in this endeavour.

Surveyors need excellent analytical and communications skills, and a sound understanding of technical knowledge relevant to their role. It is the RACGP's view that surveyors need to have worked recently in the field in which they survey, as it is difficult to understand feasibility and quality in a dynamic environment without recency of practice.

Inter-surveyor reliability is, arguably, difficult to achieve and maintain, especially when an accreditation framework already exists, in part because achieving reliability depends on duplicating some assessments and comparing the outcomes. Duplicate assessment is a burden to the site. Excellent training of surveyors will, however, assist to maintain inter-surveyor reliability.

The scope and rationale for data, privacy issues and ethical considerations need to be addressed prior to the establishment of the data transfer to provide a national 'picture'.

Although the RACGP supports the use of routinely collected data, it questions the appropriateness of using administrative data sets (often designed as the basis for payment systems) in the evaluation of health service (clinical) performance. Careful consideration of its use is needed prior to beginning any work with the data.

A nationally agreed minimum dataset based on agreed coding and classification of data will be needed for accreditation data. The RACGP supports a 'staging post' method, by which all data to be reported at a national level is provided to the relevant standards setting agency to assist in quality improvement, and passed from that body to a national data repository.

The RACGP recommends that the priority for support to move through accreditation be in the Aboriginal health sector where there is both widespread expertise, and a willingness to improve health services; but where there are very substantial demands on capacity that mitigate against the preparation for accreditation. An approach of working where 'quick wins' can be gained is likely to reinforce the 'adverse care law'.

The introduction of unannounced survey visits and 'tracer methodology' is new to Australia. The RACGP recommends that the ACSQHC ensure that an independent critical review of the strengths and weaknesses of these proposals is published prior to further work.

The RACGP supports the progress to national harmonisation of standards and accreditation. Specialist medical colleges, which have a longstanding expertise in the area, need to be central to the process, and the roles and accountabilities of the various bodies involved need to be clarified and codified, in order to support a robust and sustainable system across Australia.

Introduction

The Royal Australian College of General Practitioners (RACGP) is pleased to have the opportunity to respond to the Australian Commission on Safety and Quality in Health Care (ACSQHC) Discussion Paper – National Safety and Quality Accreditation Standards.

The RACGP addresses the issues and questions raised within the Discussion Paper largely in reverse order, as it believes that answers to some important questions raised late in the Discussion Paper are required before earlier questions can be considered.

Background to the RACGP

The RACGP is responsible for maintaining standards for quality clinical practice, education and training, and research in Australian general practice. The RACGP has the largest general practitioner membership of any medical organisation in Australia, with the majority of Australia's general practitioners belonging to their professional college. Over 22,000 general practitioners are members of the RACGP Continuing Professional Development Program. The RACGP National Rural Faculty, representing more than 4,500 members, has the largest rural general practitioner membership of any medical organisation in Australia. In addition to its quality improvement work in the education area, the RACGP has developed standards for general practices (the standards for the structure and organisation of practices). This work extends over twelve years.

Since 1996, the majority of general practices have engaged in a process of accreditation against the indicators. These *Standards* have been used as the basis for indicators of quality for general practices in New Zealand and by the optometry profession in Australia. A third edition of the *Standards for general practices* (the '*Standards*') was published in July 2005 and was recently accredited by the International Society for Quality in Health Care (ISQua).

The RACGP is collaborating with the National Aboriginal Community Controlled Health Organisation (NACCHO) in work to ensure that there are appropriate standards for Aboriginal Community Controlled Health Organisations (ACCHSs). The RACGP is also finalising development of standards for health services in Australian immigration detention centres, as a result of a request from the Department of Immigration and Citizenship to assist in this area.

The result of this work is that the RACGP has very substantial expertise in the establishment of standards.

As the development of standards has also progressed in other medical disciplines, the RACGP has continued to collaborate where possible. It is engaged in discussions with the Royal Australian and New Zealand College of Radiologists on matters of mutual interest, for example.

The RACGP is also a founding member of Australian General Practice Accreditation Limited (AGPAL), and has participated in the development of the accreditation process for Australian general practice. The RACGP receives feedback from general practitioners and other stakeholders about its standards, but in addition, receives feedback about the accreditation process.

The importance of a national framework for setting standards in health care

The RACGP supports the ACSQHC in its endeavour to develop an overarching framework for health care accreditation in Australia.

The RACGP believes, however, that an important precursor to this will be agreement on a national framework for the setting of standards.

The RACGP takes seriously its role in the setting of standards, and seeks to respond to many stakeholders who raise issues about standards in general practices, including coroners and health complaints commissions. The RACGP supports the role of other specialist medical colleges in the establishment of craft-specific standards, and seeks to collaborate with them where appropriate.

The RACGP appreciates the view expressed by many medical defence organisations that the establishment of standards in medicine is the domain of the specialist medical colleges.

Despite this, there are a wide range of organisations which either choose to have a role in establishing 'standards' or which have a legislative or regulatory obligation to set 'standards'. As a result, the RACGP is often called upon to comment on 'standards' for general practices being proposed by such bodies. Currently, for example, the RACGP is commenting on 'standards' being proposed by the Queensland Health Quality and Complaints Commission, and the Queensland Medical Board. The RACGP has responded to proposals for standards for other medical boards and health complaints bodies, from government departments (at both State/Territory level and at Commonwealth level), and from bodies such as Standards Australia.

This work often involves explaining the duplication of effort being undertaken by these bodies, or explaining the inappropriate nature of the proposed standards for the Australian general practice context.

The RACGP would be supportive of a wider discussion about the use of taxpayer funds in such duplication, and whether it might not be better used to support the important work of professional bodies.

Arguably, some governmental and quasi-governmental bodies have the view that their legislative or regulatory base provides them with authority to impose standards on health services. Where the general practice profession sees such standards as lacking a sound basis in evidence, are seen as lacking feasibility, are seen as lagging behind contemporary evidence (and need legislative or regulatory reform), or are seen as unnecessarily onerous, there is little in the way of a framework which addresses the legitimacy of such organisations to create and enforce standards in contrast to professional bodies.

The process of monitoring adherence to these standards varies. It includes self-reporting, and the use of the standards in judicial or quasi-judicial contexts as a benchmark (in effect monitoring by exception). The RACGP is concerned about the variability of these processes, recently needing to advise a general practitioner that four different organisations had established 'standards' on an issue; that the 'standards' varied, and that the general practitioner would need to consider adherence to all of the 'standards' as each body had a separate, differing punitive action for non-adherence. Such a situation is unsatisfactory.

Of some importance in this arena is the increasingly apparent problem that arises from the application of the 'precautionary principle' in some public health areas. The RACGP's view is that this is likely to result in a compliance burden for general practice where there is little or no demonstrable risk; where the cost of compliance is completely disproportionate to the risk. The clearest area of challenge at present is in waste management, where the involvement of Environmental Protection Agencies may result in substantial costs being incurred to protect against risks taken in the community on a daily basis.

The RACGP has formed the view that the role of specialist medical colleges is being undermined by some stakeholders, rather than supported. The RACGP believes that this is not in the long-term interests of the community.

The result of these interactions is that the RACGP has formed the view that it would be very helpful for the ACSQHC to consider facilitating a national framework for standards setting, in which the roles of the stakeholders were clear; and that such a framework may be an important precursor to national agreement on an approach to health care accreditation.

The impact of the fault-based tort law environment

Australian general practice is diverse. The RACGP sought legal advice about the establishment of standards, as it plays the role as the national leader in defining standards in general practice. The legal advice provided to the RACGP is that the indicators in the RACGP's *Standards for general practices* could play a potential role in the identification of a widely held peer professional view (currently the tort law test for the standard of care in at least one Australian state). As a result, making the requirement too rigorous (higher than most 'quality' practices currently achieve) may increase the risk of litigation unnecessarily. This feature of the Australian environment meant that the RACGP needed to carefully consider the feasibility of practices achieving the indicators.

The characterisation in the Discussion Paper of standards being 'minimum safety standards', 'best practice' or 'optimal achievable' standards does not address the impact of the tort law environment satisfactorily.

The 'normative' level at which the RACGP sets its standards is not described by any of the three definitions proposed within the Discussion Paper, with the first definition being at a level below that which the RACGP (reflecting the views of general practice and its stakeholders) would consider appropriate; and the two latter definitions being at a higher level than is 'normative' and potentially creating problems for well-functioning general practices.

Purposes of standards

It is disappointing that the Discussion Paper largely ties issues of standards to issues of accreditation.

The Discussion Paper itself indicates that standards are developed to protect public from harm, and to improve quality of service provision. Accreditation can be an element of those actions, but is not the only, and may not be the most important, action.

The purpose of the RACGP's *Standards* has been, and continues to be to engage the profession in a comprehensive, continuous quality improvement process focused on patient safety.

The general practice profession has written the RACGP's *Standards* for use by general practices. Practices can self-assess against the *Standards* as part of their quality improvement process, or they might collaborate with other practices to assess each other. A practice that is undertaking its own assessment against the *Standards*, might consider discussing the assessment informally with a trusted colleague. A 'fresh set of eyes' over practice systems can assist in identifying areas in which the practice does well, as well as those that require improvements. Peers can make judgments that take into account all factors, not just the inspection of a checklist that could be conducted by a trained person. Peers can also provide feedback to the practice on innovative ways it could improve, and can exchange ideas on what will work best in the practice's environment. Most importantly, peers can provide feedback on quality improvement activities – they can help identify if changes have brought about the intended outcomes or if there are other things that the practice can do to improve quality.

To focus on standards only, or principally, as an underpinning of accreditation is to diminish the fundamental importance of self-improvement. The RACGP's position is that there is a danger that performance measurement frameworks may simply displace existing informal and internal modes of quality assurance, and run the risk of assuming that informal processes do not take place. The irony is that new structures may displace these systems and undermine the conditions of trust required for quality improvement.

Thus, the RACGP argues strongly for an overt recognition of, and support for, the professional role of standards and quality improvement beyond the seeking of accreditation.

Many practices choose to be assessed against the *Standards* by a third party to gain formal 'accreditation' against the RACGP *Standards*.

Where standards are used for comparison purposes, risk adjustment is essential to ensure fair comparison. This is difficult to do well, and Australian doctors have expressed concern about the failure of clinical indicators to account for patient or practice diversity. As a result, the theoretical and practical issues of risk adjustment need to be addressed prior to any comparison being made on the basis of accreditation. If this is not done the standards are undermined.

Proliferation of Standards

What initiatives are required to coordinate and harmonise standards development?

The RACGP's view is that initiatives that cross the specialist medical colleges are central to the coordination and harmonisation of standards. For example, the RACGP has undertaken detailed work on infection control standards for office-based practice – work that is applicable to the settings of practitioners in some other medical crafts and for other primary care contexts. Joint work in such arenas would allow for the coordination and harmonising of standards. Supporting specialist medical colleges that are already advanced in various areas to work with other professional stakeholders might assist.

Such work, presumes, however, a national framework that describes the roles of the various parties, and thus minimises duplication by the diverse parties involved.

Process of developing standards

What aspects of Australian health care standard development should be standardised for more streamlined, effective and efficient standards development?

It would be helpful if the delineation of 'standards' were clearer and widely agreed. Some documents that the RACGP reviews are probably better characterised as protocols or procedures, despite being called 'standards' by the authors. This is not to criticise their accuracy, but to endeavour to separate the functions of standards setting.

This may reflect different theoretical and conceptual views on standards (eg their purpose and their audience); and the RACGP would recommend to the ACSQHC that it facilitate discussion about the theoretical and conceptual underpinnings of standards amongst those who develop them for Australian healthcare settings.

It may be possible to agree on a series of core activities required in the setting of standards (eg the scope of consultation, and the pilot testing of standards), though the RACGP's position is that it would be difficult to 'standardise' the activities as they may need to be carried out differently in different settings or crafts.

The RACGP's experience is that it is difficult to standardise content across widely divergent settings, as the indicators of quality need to be relevant to, and measurable in the specific setting.

Appropriateness of Standards

How do you ensure that the standards being assessed are appropriate?

To ensure that standards are appropriate requires agreement on what 'appropriate' means. There are a number of indicators of 'good' standards, which include their relevance to the setting, their validity and reliability. Appropriate standards for the purposes of research might, for example, require more emphasis on the 'purist' characteristics of reliability, sensitivity and validity; whereas appropriate standards for implementation in day-to-day practice and quality improvement may need more emphasis on relevance and acceptability. The RACGP has taken a relatively pragmatic approach to its work, as it believes that the utility of standards is in their day-to-day application in the workplace.

The RACGP ensures that its standards are appropriate by:

- Consulting general practice and its stakeholders during the development of its standards
- Pilot testing the standards, and
- Monitoring feedback on the standards following their implementation.

Registration of sets of health care standards

What needs to be in place to make this approach feasible?

In the RACGP's view it will be necessary to have both a framework for standards development, and agreement on the delineation of 'standards' before it will be possible to register standards.

The framework will assist to ensure that all bodies that have a legitimate role in establishing standards are known, and their role in having standards registered is agreed. The delineation of 'standards' will assist in clarifying what needs to be registered (and what does not).

Which organisation is best placed to manage the longer term register of standards?

The RACGP has not considered this issue, and would prefer that further consultation on this matter occur, when the framework for standards development is clearer.

Detailed mapping of standards

Who needs to be involved in this mapping process?

Decisions about who needs to be involved in such a mapping process seem to be contingent on agreement about the parties that have legitimacy to establish standards, as all bodies involved in standards setting, especially accredited specialist medical colleges need to be involved.

Identification of core safety and quality area

What priority areas should be included in core safety and quality standards?

The RACGP's position is that the priorities need to be relevant and meaningful to the clinicians involved, as this will assist in creating 'buy-in' to the process of meeting standards.

The RACGP's view is that decisions about priorities need to be preceded by an agreement about the way in which risks to safety and quality are characterised or classified.

For example, communication systems, processes and skills may be an important priority area, as there is a body of evidence suggesting that lapses in communication systems and processes are common causal factors in medical error. Alternately, the same error might be conceived of as a 'medication error', with the result that 'medication safety' might be a priority area to address. It is possible that both approaches might be adopted, however, if this occurred such an approach would need to be coordinated such that organisations that were tackling the safety issues through a 'communications' strategy were not criticised for not tackling 'medication safety'.

Harmonisation of health service standards

What are the barriers to standardisation of language and definitions?

The RACGP supports standardisation of language and definitions where this is important to national strategies for reporting and research.

There are, however, a number of impediments to this process.

The RACGP is aware, for example, that it uses the terms 'standards', 'criteria' and 'indicators' somewhat differently to some other organisations. There is, however, a history of using these terms in Australian general practice that is over ten years long. As a result, the RACGP has consciously chosen not to change its use of the terms, as it decided this would not be productive at this point.

There are different views on 'best practice' in standards setting which underpin some differences in terminology, and these would need to be addressed.

Finally, standards are used in different domains (eg. acute sector and the community-based sector). This may create impediments to standardisation of language as some terms are used somewhat differently in the different domains.

Who needs to be involved in this standardisation process?

The RACGP supports the involvement of standards setting agencies in this standardisation, and acknowledges that this will result in a flow-on impact on accreditation agencies.

Access to Standards

What information should be publicly available on accreditation standards?

Versions of the standards used by the profession, and against which settings are accredited should be readily available to stakeholders. The RACGP has facilitated this by making most of its standards available on its website.

There is, however, an unresolved issue of the protection of intellectual property in the e-environment. Standards can be costly to develop, and can be costly to publish. The risk that the capacity to continue (re)development is undermined by widespread access needs to be considered.

The RACGP has taken the view that its *Standards* need to be available to the community; however, it has not provided such ready access to its infection control standards – reflecting the focus on profession use, rather than public access. This is not entirely a comfortable outcome, and it reflects the problems arising in providing access to standards.

Mutual recognition of standards and accreditation processes

What is required to implement mutual recognition of standards and accreditation processes in the Australian health care system?

The RACGP suggests that good will, a framework that addresses accountabilities and roles, and adequate funding are needed to achieve mutual recognition. Many of the standards setting organisations are member-based, and mutual recognition may have little impact on the members (and thus be low in the agenda for further investment by members).

The starting point needs to be mutual recognition of standards. Mutual recognition of accreditation is a subsequent step.

In this context, it is important to note that both standards and accreditation need to be the subject of review. The RACGP has had its standards reviewed independently by the International Society for Quality in Health Care, and independent bodies credential both accreditation agencies in general practice. The RACGP suggests that the Commission consider whether harmonisation of this process, and independent credentialing of standards and accreditation needs to occur through the Australian context.

Standardise accreditation language and definitions

Who needs to be involved in the standardisation of language and definitions?

As previously indicated in this response, the RACGP's position is that standardisation of language needs to occur in standards setting prior to consideration of the issues for accreditation. Accreditation bodies need to adhere to the language and definitions of the standards.

Effectiveness of identifying poor performance

What core processes or systems need to be in place to ensure that poor performance is detected? Is this necessarily part of an accreditation process?

The RACGP proposes that the following are necessary for the detection of poor performance:

- Well written standards with 'good' indicators that are sensitive to quality and thus can be used to detect lapses in quality
- Effective surveyor training, especially in the underlying theories of safety, technical issues appropriate to the field and the skills of discussing sensitive matters with peers
- Qualified privilege, as the RACGP is aware of attempts to subpoena accreditation documents; and continues to get feedback that surveyors and practices are concerned about the potential to be enmeshed in legal proceedings through their participation in quality improvement initiatives.
- Mechanisms for feedback from other organisations e.g. Medical Boards, health complaints commissions.

Where there is a systems failure, how should the accreditation body respond?

The RACGP supports an escalated response based on the principles of natural justice. In the first instance, where possible the issues need to be raised directly and privately with the organisation involved, and with the relevant governing body (eg. organisational owners) if appropriate. It may be appropriate to raise the issue with both health complaints bodies and/or professional boards.

Transparency

What is essential to ensuring all accreditation processes are open and transparent?

The RACGP's position is that it is essential that comprehensive data be reported to the standards setting body in order to ensure that continuous quality improvement of standards occurs.

It is also important that appropriate, regular reports are made to consumers, especially where qualified privilege is granted. Reporting also needs to occur to professional bodies in order to ensure that lapses in quality that are amenable to improved training, for example, are identified and acted upon.

What minimum information should be publicly available on the accreditation status of health services?

The RACGP's position is that it is appropriate for consumers to be able to know whether or not a health service is accredited, and against which standards. Consumers need to know the date of next review, and the place where they can lodge a complaint if they believe the service does not meet the standards against which it is accredited.

It is critically important that any public comparison be grounded in appropriate risk adjustment. Unless this is done, the credibility of the comparison is undermined. The RACGP would oppose the release of raw data that is not risk-adjusted.

The RACGP is aware of evidence that few consumers use such information in their health care choices, and would support ongoing strategies that raise consumer awareness of the role accreditation can play.

Governance

What governance issues must be addressed by organisations setting standards, training surveyors or accrediting health services?

There are a number of governance issues that need to be addressed by organisations involved in standards setting and accreditation.

The RACGP strongly supports the role of specialist medical colleges, and the self-regulatory role that they have taken in developing and promoting standards.

There is a perceived conflict of interest when an organisation that sets standards also plays a role in accreditation, especially where the accreditation operates within a competitive market. On the other hand, without a substantial 'forcing function', it may be difficult for a standards setting body to ensure that its standards are used and interpreted appropriately. Additionally, input by the standards setting body into the form and outcomes of accreditation can be useful to all parties. The RACGP recommends that consideration be given to the advantages and disadvantages of the models that exist in Australia, and some consistency be sought.

This issue bears on the authority to require use of standards (eg. by licensing and regulatory bodies). The responsibilities of the bodies need to be clear.

The involvement of community representatives and consumers in governance is important to consider, and is supported by the RACGP.

Duplication and overlap

What needs to be done to integrate and streamline overlapping accreditation processes?

Because accreditation follows the process of standards development, the ability to integrate and streamline accreditation is grounded in the clarification of the roles of standards-setting bodies.

This is likely to involve a continuous process of negotiation as boundaries change.

The RACGP holds the view that professional colleges are likely to be keen to collaborate on such integration as the accreditation cost directly affects their members.

Resource requirements

How can accreditation be made more cost efficient and effective?

Accreditation needs to be based on relevant, clinically meaningful accepted and achievable standards. The feedback to the RACGP, generally, is that concerns arise where the standards are seen as 'nit-picking', based on little evidence, or irrelevant to the delivery of safe, high quality care.

The quality of surveyor training is also important, as the other issue raised by stakeholders with the RACGP is the importance of surveyors being able to see 'the wood for the trees', and focus on the underlying safety principles in their assessments and provide a consistent approach both between accreditation cycles for individual practices, and between practices on a particular issue.

An integrated set of standards and accreditation process is seen by many of the RACGP's stakeholders as desirable and cost effective; and the RACGP continues to work with key stakeholders affected by multiple standards to achieve such integration.

Surveyors

What are the essential skills, competencies and attributes that surveyors need?

Surveyors need excellent analytical and communications skills, and a sound understanding of technical knowledge relevant to their role.

It is the RACGP's view that surveyors need to have worked recently in the field in which they survey, as it is difficult to understand feasibility and quality in a dynamic environment without recency of practice. The RACGP does not support the use of people who have no direct experience working in the field.

The RACGP does not support the use of consumers as accreditation surveyors in general practice and is monitoring the research literature concerning the ability of consumers to make assessments of quality in primary care.

What needs to be in place to train and assess surveyors effectively?

Structured pre-survey education and training at the standard of the relevant professional body needs to occur. It needs to include input on the theories of quality improvement, systems thinking and patient safety. The training needs to be relevant to the setting in which the assessment will be taken.

What must be done to ensure inter-surveyor reliability?

Inter-surveyor reliability is, arguably, difficult to achieve and maintain, especially when an accreditation framework already exists. This is because achieving reliability depends on duplicating some assessments and comparing the outcomes (unless there is a 'gold standard' against which the assessment can be validated). Duplicate assessment is a burden to the site and has little direct benefit to the site.

Good training, especially about the underlying principles that underpin the decision-making, is likely to assist. Access to the standards setting body for input regarding interpretation of the standards, may also assist, as would the provision of feedback from the sites being assessed.

What strategies need to be put in place to ensure that there is available a sustainable supply of credible and competent surveyors?

The educational benefits of structured surveying need to be considered by professional bodies, and their continuing professional development programs need to incorporate recognition of the educational benefits of surveying.

It is important for a range of organisations, including employers and workforce planning bodies to acknowledge that surveying is a core professional obligation, and that time for surveying needs to be built into workforce projections and work contracts. This may be harder to achieve in the private sector, but principle still applies – most people need to participate in some accreditation activities, in order for them to be sustainable.

Information to support accreditation

What needs to be in place to allow accreditation data to be collected at a national level?

A nationally agreed minimum dataset based on agreed coding and classification of data will be needed. The RACGP supports a 'staging post' method, by which all data to be reported at a national is provided to the relevant standards setting agency to assist in quality improvement, and passed from that body to a national data repository.

The question of how compliance with data transfer will be ensured also needs to be addressed. The RACGP supports a self-regulatory model, if that can be established.

What needs to be in place to allow accreditation data to be made available?

The nature of the data, especially its limitations must be understood by both the agencies that are publishing the data, and those who will be using (and interpreting it). This is particularly the case if there is to be any comparison made on the basis of the data.

Privacy issues and ethical considerations need to be addressed prior to the establishment of the data transfer. The RACGP has heard of suggestions for data aggregation that include transfer of clinical data that might signal gross lapses in quality. Were any such data to be the subject of transfer, then the ethical and legal obligations of the parties to pursue the safety of patients needs to be clear prior to transfer.

It will also be important to have an efficient data transfer system, in order to ensure that reporting bodies are able to provide the data easily.

Register of accrediting bodies

Currently there is little information or explanation of what accreditation has tested and what it means for the consumer – this is an issue for the standards-setters first.

What needs to be in place to make this approach feasible?

Which organisation is best placed to manage the registration of accreditation bodies?

Better use of data for evaluation of health service performance

How can the available data sets be best used to inform accreditation processes?

There are two levels of analysis involved in this issue.

The focus of the RACGP has been on quality improvement at practice level, and the RACGP supports the use of routinely collected clinically relevant data to identify opportunities for improvement within services. If rigorous risk-adjustment models can be identified, then it might be useful to use available data to benchmark service processes and outcomes. Whether or not that needs to be an element of an accreditation process, particularly in primary care where many other factors intervene on patient outcomes, needs further discussion.

Available data might be able to identify priorities for quality improvement, as discussed earlier in this response to the Discussion Paper. Were this to be the case, the consideration would need to be given to whether elements of standards and accreditation that focused on these priorities were enduring features of standards and accreditation, or had a limited life. Unless they have a limited life, it is possible that standards and accreditation will grow incrementally, and that there will be growing concerns about the cost-benefit of meeting standards and accreditation. The literature in the field describes a number of disadvantages to accreditation where there is consistent (poor, or good) performance in an area, especially accreditation models that use benchmarking. These issues need careful consideration prior to the use of available data sets.

Finally, there is an ongoing discussion in the literature about the appropriateness of using administrative data sets (often designed as the basis for payment systems) in the evaluation of health service (clinical) performance. The use of such data has been considered and there are quite divergent views about its utility.

System wide accreditation against safety and quality standards

Which health services should be accredited as a priority, and how can this be best achieved?

It is not uncommon for initiatives such as enhancements in accreditation coverage to focus on areas where they can be 'quick wins' – where the rate of accreditation can be boosted quickly.

The RACGP is concerned that such an approach would leave many services that are working with highly disadvantaged populations until 'later'. The RACGP would argue that these services, many of which have little discretionary capacity to prepare for accreditation are, in fact, the top priority for focus. The alternative potentially reinforces the 'adverse care law'.

The RACGP recommends that the priority be in the Aboriginal health sector where there is both widespread expertise, and a willingness to improve health services; but where there are very substantial demands on capacity that mitigate against the preparation for accreditation.

Introduction of unannounced surveys

What needs to be done, and by whom, to introduce unannounced surveys in a timely and effective way?

The introduction of unannounced survey visits is new to the Australian context. The available information appears to describe, but not critically appraise, the introduction of the method in the United States of America. The RACGP is keen to see peer-reviewed papers on the benefit of the model (or similar models). The Commission needs to ensure that an independent critical review of the strengths and weaknesses of the proposal is published prior to further work.

The RACGP's view is that it is very important to bring the profession along with potential improvements in standards setting and accreditation; and thus that it is important that unannounced surveys not be conceived of as an (additional) imposition by authorities.

Key parameters of any such approach need to be agreed, including:

- The form of the visit (a complete survey visit, or some parts of it)
- The choice of sites surveyed (random, or not; and if not what are the criteria used)
- The implications of the visit (less frequent surveying for those who 'pass' an unannounced visit, compared with those who have not had one – which creates an uneven 'playing field'; loss of accreditation – immediately?)

The RACGP recommends a detailed briefing of standards setting agencies prior to the promulgation of the model within accreditation agencies.

Introduction of tracer methodology in external accreditation reviews

What needs to be done and by whom, to introduce tracer methodology in a timely and effective way?

The idea of 'tracer methodology' is new to the Australian context. A rapid search of available information by the RACGP indicated that most material was descriptive in nature. In that context, the RACGP is keen to see the peer-reviewed demonstration of benefit from the methodology. The Commission needs to ensure that an independent appraisal of the costs and benefits of the methodology is made available to Australian stakeholders before further progress is made.

The RACGP's view is that it is very important to bring the profession along with potential improvements in standards setting and accreditation; and thus that it is important that tracer methodology not be conceived of as an imposition by authorities.

As a standards setter, the RACGP's view is that the introduction of this methodology is likely to have an impact on the way standards are written. As a result, the RACGP recommends that the ACSQHC provide detailed briefings on the methodology prior to pursuing its promulgation in to the accreditation sphere.

Conclusion

The RACGP supports the progress to national harmonisation of standards and accreditation. Specialist medical colleges, which have a longstanding expertise in the area, need to be central to the process, and the roles and accountabilities of the various bodies involved need to be clarified and codified, in order to support a robust and sustainable system across Australia.

Contact

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