



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**

**Consultation Paper
An alternative model for safety and quality
accreditation of health care**

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) Consultation Paper – An alternative model for safety and quality accreditation of health care.

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.

Although the RACGP's position is that the welfare of the Australian community is its paramount concern; the RACGP believes that this is compatible with a focus on the safety of general practitioners and their teams.

The RACGP takes the position that the perceived problems with accountability and transparency need to be more clearly enunciated before decisions about alternative models are made.

The RACGP supports the identification, and incorporation into standards, of a number of high priority safety issues, rather than the creation of separate safety standards. It is possible that this approach could lead to a new model of random, unannounced visits. If this were the case, then the approach would need to cover the entire health sector.

The experience of the RACGP suggests that it is impossible to completely avoid conflict of interest between standards setting and accreditation; and as a result that careful deliberations about the conflicts and their impact need to occur. The endpoint needs to be the conscious minimising of key risks, rather than a perceived attempt to eliminate them.

The RACGP supports meaningful and affordable accreditation of all health care settings, and supports a process of prioritising settings for inclusion in a national scheme of standards and accreditation, based on the likely risk to the safety of patients (and health care providers).

For the purposes of health care accreditation, health care settings should be deemed to meet non-clinical standards, and should be included in routine quality assurance as are other settings. With respect to technical standards, the system needs to ensure that both patients and general practices can benefit promptly from advances in technology that allow safe activities previously captured by regulation.

Medical specialist colleges appear to share a number of elements of a quality improvement framework. The reform process could productively build on this common base.

The RACGP is keen that the accountabilities of any proposed national entity be clarified. In particular, the accountability to health professionals through their representative organisations needs to be clarified.

While the RACGP supports a review of surveyor training, the RACGP believes that it would be prudent to have this follow decisions about the scope and nature of the standards setting and accreditation.

The RACGP supports the role of medical specialist colleges in standards setting, and believes that their expertise could be used in the reforms. More work needs to occur on the issues associated with unannounced visits and tracer methodology.

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) Consultation Paper – An alternative model for safety and quality accreditation of health care.

Prior to addressing the issues and questions raised within the Consultation Paper, the RACGP makes some preliminary comments about the overall issues of accountability that appear to underpin the Consultation Paper.

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 23,500 general practitioners are members of the RACGP Continuing Professional Development Program. The RACGP National Rural Faculty, representing more than 5,200 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 (ACCHOs). 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.

Preliminary remarks – accountability and clarity

The safety of patients is paramount

The RACGP's position is that the welfare of the Australian community is its paramount concern.

In that context, the central aim of any Australian standards-setting and accreditation system needs to be to protect the safety of patients. The murder of Dr Khulod Maarouf-Hassan in 2006 resulted in a stronger focus in Australian general practice on the safety of general practitioners and the members of their teams. The RACGP takes the position that protecting the safety and wellbeing of general practitioners and the members of their teams is compatible with protecting the safety of patients; and that both can underpin an Australian standards-setting and accreditation system.

Accountability – what is the problem?

The Consultation paper outlines two aims of the proposed reform and the resulting 'alternative model'. These are:

- To provide greater accountability and clarity, and
- To reorientate relationships between existing bodies.

The second of these needs to be contingent on the first – the (re)orientation of relationships between existing bodies needs to be based on a system that supports transparency and accountability.

The Consultation Paper indicates that

“Ministers are held accountable by the community for the safety of the health system ...”

This is, however, a limited view of the issue of accountability.

In addition to the accountability of Ministers to their constituents, general practitioners and their teams (in the context of the RACGP) are held accountable for the safety of the health care in general practice, through the complaints, medical board, tort law and vicarious liability arrangements, or organisational clinical governance.

Arguably, if there is a problem with accountability one or more of these arrangements fails the Australian public and the profession, and the problem needs to be clearly defined. The RACGP sees medical boards as having a critical role, as they, almost unilaterally, have the ability to remove unsafe practitioners from the system.

The RACGP believes that an alternative model needs to be premised on clarity about whether there a perceived problem with:

- The role and/or powers of complaints bodies
- The role and/or powers of medical registration boards
- The use of tort law and laws relating to vicarious liability
- Clinical governance in Australia.

If there is a perceived problem that undermines accountabilities, then the proposal needs to address this, as many of these arrangements are amenable to change through the State/Territory jurisdictions, or the Australian Government, without change to the existing accreditation system.

Transparency – what needs to be improved?

The RACGP supports the maintenance of a transparent system that can provide the community with information about the safety of the health system.

In the Australian context, a number of mandatory reporting arrangements already exist (for example, reporting to and from the Coroner's Courts). These are largely separate from the existing accreditation schemes which (at least in general practice) are focused on quality improvement.

The tenor of the Consultation Paper is that these existing systems fail to provide the community with sufficient information to address concerns about the ongoing safety of the health system. The Consultation Paper implies that these arrangements are insufficient for Ministers.

Before the RACGP would support any further development of mandatory reporting for public safety, it would want to see a clearly argued case for the failure of the existing mandatory arrangements (i.e. how and why have they been ineffective). It would also want to see the reasons for not refining and enhancing the existing systems, but rather creating a further system (as is proposed in the Consultation Paper).

The imposition of (further) mandatory safety assurance is a regulatory imposition, and a transparent regulatory impact statement needs to be sought.

Two things need to be clear prior to proceeding in the direction of safety assurance:

- That the improvement in patient safety expected to occur from (further) regulation outweighs the cost
- That the proposed reporting/regulation is the least costly option of achieving the expected improvement in patient safety (i.e. that using the resources in other quality improvement initiatives would not bring at least the same improvements to patient safety).

It appears that what might be sought is nationwide reporting of the quality assurance and quality improvement effort in key areas of risk (to patients and health care workers). If this is the case, then the RACGP proposes a model later in this response.

Reorientation should result from the decisions about accountability and transparency

With respect to the reorientation of relationships between existing bodies it appears that there are a number of realignments proposed:

- To separate the role of standards-setting and the role of assessing against standards
- To coordinate and where possible, to integrate, standards setting and assessment, with the aim of minimising complexity and duplication.

Arguably, the resources involved in the transition to the new safety assurance model and its maintenance (transition and transaction costs) would bring about substantial improvement in patient safety if they were used to promote skills in the discussion of safety related concerns amongst peers, or in achieving an accessible electronic health record. It is important that this trade-off be considered, and that the reorientation that which is needed to enhance accountability and transparency.

Feedback of issues raised in the Consultation Paper

1. Separation of safety assurance and quality improvement assessment process

The alternative model proposes separating safety standards setting (and processes to assess them) from quality standards setting (and processes to assess them). Safety assurance and quality improvement will be prescribed through minimum safety standards, while quality improvement will be delivered within a framework which encourages continuous improvement.

The Commission is seeking stakeholder input on:

- *The appropriateness and effectiveness of separating safety assurance and quality improvement*
- *Timeframes for the implementation of a separation of safety assurance and quality improvement; and*
- *The resource implications of this change and funding options that should be considered.*

From the perspective of the RACGP, safety is about the reliability of 'good' performance in the health system. In that context, the RACGP considers it to be unhelpful to distinguish between safety assurance and quality improvement.

The tenor of the Consultation Paper suggests that there is consensus that there are some major areas of risk to patients (and health professionals) in the health system.

There is a paucity of high quality data about major areas of risk to patients in Australian general practice, deriving, in part, from a consistent under-investment in targeted research. Despite this, there is a growing consensus about areas of harm (e.g. medicines).

The RACGP used this information as a basis for decision-making during the development of its *Standards for general practices (3rd ed)*. As a result, to the degree that it was feasible for general practices, major areas of risk are addressed in these *Standards*.

The RACGP would support a process that led to national consensus on key areas of risk to patients (and health professionals).

There is, however, a body of literature that suggests that it is unhelpful to single out specific processes or structures as ensuring safety. Many are likely to be necessary to patient (and health professional) safety. However these aspects will not be sufficient to ensure safety, if taken alone. Thus, to target the risks to the exclusion of other aspects of quality may not be successful in reducing overall harm. Additionally, there is evidence that the identification of key areas of focus shapes behaviour, sometimes in ways that are 'perverse', and may undermine the safety and quality endeavour in other areas. This would be particularly concerning in general practice, where a holistic patient model is central.

The RACGP believes that it is premature to discuss the timeframes for implementation of a separation of safety assurance and quality improvement. The whole concept is subject to challenge, and it is not clear that there is a consensus that this model would be preferable to enhancing existing arrangements.

The RACGP's alternative to mandatory safety standards:

Were there agreement about key areas of risk to patients (and health professionals), then the RACGP would support a process that considered whether it would be appropriate to mandate these components be included in health care standards in Australia.

If better data is needed on achievement of these standards is needed in order to continue to assure the public that these key risks are being identified and addressed, the RACGP would support consideration of a nationally coordinated strategy to collect data about the degree to which standards are achieved.

The indicators would need to be 'good' indicators. For example, they would need to be clinically meaningful to those collecting the data, and easy to collect.

The data collection might occur, for example, through a randomised survey of health settings (including general practices). A survey of specific issues (e.g. infection control) could be part of a broader survey of whether a practice meets other standards within the setting. Any randomised process would need to follow an initial accreditation of any new setting (or setting not previously accredited), in order to ensure that all relevant processes and structures for quality improvement were in place.

Should such a survey model be considered, then the RACGP would propose that specialist medical colleges be central to the way in which settings are targeted.

It would also need to a sector-wide approach. There are an increasing number of settings which have different services. In that context, it would be difficult to have a cyclic model of accreditation (e.g. each three years) in some parts of the setting, and a randomised model in other parts of the setting.

The RACGP's position is that the data would need to be reported to the RACGP, as its reporting into the public domain would need to be done with appropriate interpretation of its impact on the community. The data could also be reported to a national body as part of a national strategy.

The RACGP is confident that targeted, confidential reporting, based on evidence of risk to patients (and health professionals) would be accepted in general practice, if led by the RACGP.

Such a model would allow the focus of the randomised survey to be changed as the risks to patients (and health professionals) change.

2. Separation between safety standards development and assessment of health services

The alternative model proposes there be a separation of safety standards development and assessment of health services.

The Commission is seeking stakeholder input on:

- *The mechanism for achieving this change*
- *Timeframe for the implementation*
- *The resource implication of these changes and funding options that should be considered.*

The RACGP has been an organisation involved in standards setting, though not directly in assessment of health services.

It continues to hold the view that standards-setting is the province of accredited medical specialist colleges (and similar bodies in other professions).

Absolutely central to the success of any National Entity that developed standards would be a central and decisive role for medical specialist colleges. Such a role is absent from material outlined in the Consultation Paper.

It is the RACGP's experience over more than ten years, that in the final analysis, particularly where any sanction applies or where substantial investment is involved, experts in the field will be needed to arbitrate over whether some settings achieve the standards. This will, by necessity, involve specialist medical colleges (and other relevant professional bodies). As a result, it will be difficult to completely sever the tie between setting standards and accreditation.

The current discussion occurring about the status of the Royal Australian and New Zealand College of Radiologists' standards in a regulated accreditation system may be instructive.

The current approach appears to require the relevant jurisdiction (in this case the Commonwealth) to own the standards (i.e. in effect, to set the standards); and also ties the jurisdiction to the assessment process. Arguably, the same issue arises with the standards in the residential aged care sector.

The RACGP is concerned that the 'capture' of the accreditation system by regulation appears to supplant the legitimate ownership of professional standards by the relevant professional bodies. This is unacceptable to the RACGP which believes that the maintenance of the currency of standards and their acceptance within the craft is intrinsically tied to professional ownership of standards. It also appears to be contrary to the separation of roles proposed within the Consultation Paper.

The RACGP cannot advise on the mechanism for achieving the change, the resource implications or the timeframe in a situation where the future standards setting and accreditation model is explored to the extent of the Consultation Paper.

The RACGP is keen to know:

- Whether all existing formal and informal standards setting bodies would form part of the National Entity (if not, why not)?
- What governance arrangements are proposed?
- Whether the accreditation model will be regulated, and if it is, whether the standards against which accreditation occurs will be enshrined in legislation/regulation, as they appear to be in the aged care, and radiology areas.

3. Accreditation of all settings of care where services are provided by registered health professionals

The alternative model proposes that health services provided by any registered health professional will comply with national minimum safety standards and implement the quality improvement framework. For service where no accreditation system currently exists, the initial requirement will be compliance with national minimum safety standards and regulatory compliance only. A staged introduction of compliance with the quality improvement framework will follow.

The Commission is seeking stakeholder input on:

- *The appropriateness of including services provided by registered professionals, where they are registered in only one or two states and territories;*
- *Transition arrangements required to implement the assessment of national minimum safety standards in all settings of care;*
- *A prioritisation process for the staged implementation of changes for services that are not currently accredited;*
- *Timeframes for the implementation of safety assessment processes;*
- *The resource implication of these changes and funding options that should be considered; and*
- *Incentives that could be considered.*

The RACGP supports a 'level playing field' in standards setting and accreditation.

The situation in which some professionals are registered in some jurisdictions and not others argues for a national approach to registration.

Despite that, the RACGP would prefer that all settings where registered practitioners provide services are accredited (even if there is some variation across Australia).

The RACGP continues its focus on the balance between risk to patients (and health workers), and the safety intervention. In that context, the key consideration for prioritising the setting of standards and implementation of accreditation needs to be degree of risk to patients. While such repositories are imperfect, the experience of registration boards, complaints commissions and Coroner's Courts are likely to point to the high priority areas.

While the introduction might be prioritised, the RACGP's position is that all settings need to be accredited, otherwise there will continue to be 'holes' in the safety net of a patient's journey across settings.

The RACGP supports the view that improvements in safety and quality are best achieved by meaningful incentives to people and organisations which engage in those improvements, and would support incentive payments.

The RACGP has been reviewing the evidence about so-called 'pay-for-performance'. Further, detailed exploration of the models and their application in Australia would need to occur before the RACGP could support a 'pay-for-performance' or 'pay for quality' model in the primary care sector.

4. National minimum safety standards that apply across all settings of care

The alternative model proposes a process to develop national minimum safety standards endorsed by Health Ministers, that sits within a national minimum safety standards framework.

The Commission is seeking stakeholder input on:

- *The criteria and processes for determining national minimum safety standards. For example, the National Entity could develop standards directly (using working groups of technical experts, consumers and other stakeholders) or it could outsource to an appropriate body or collaborative;*

- *The areas to be addressed by the standards and the coverage of each standard;*
- *The priority order for the development of standards, which may be risk-based;*
- *Whether the assessment outcome against minimum safety standards should be pass or fail*
- *What failure would mean for a health service*
- *Under what circumstances a 'fail' rating would be applied*
- *Sanctions or penalties that would result*
- *Mechanisms to ensure that mandatory compliance against national minimum safety standards. Detailed consultation with jurisdictions on how to most effectively implement mandatory compliance will be undertaken by the Commission*
- *Options for assessing national minimum safety standards and mechanisms to reduce the subjectivity of the outcome and inter-assessor reliability. For example, they may be suited to assessment through desk-top audit and complemented by unannounced surveys*
- *Mechanisms to recognise bodies to assess against national minimum safety standards. For example, the approval process could include agreement by the assessing body to provide assessment information to the national entity and for them to be externally accredited by independent bodies such as ISQUA and JASANZ. There may also be specific requirements about training, competence assessment, performance management, experience and reliability of assessors.*
- *Information assessment bodies will be required to provide to the National Entity on assessment outcomes against the national minimum safety assurance standards*
- *Resource implications of these changes and funding options that should be considered.*

There is an extensive literature on the characteristics of 'good' indicators of quality and safety. This needs to form the basis of work on safety and quality standards. In particular, the RACGP has the view that there needs to be a careful consideration of the trade-offs between the rigour of standards (their validity, reliability and sensitivity, for example); and the potential to implement them readily (e.g. their acceptance by the profession, the ease of collecting the necessary information, and their relevance to the day-to-day clinical work of the health professionals).

In terms of the areas to be covered, the principle underpinning the scope of safety standards needs to be that material risks to patients (and health professionals) are addressed.

To date, the focus of such work has been the hospital system. As demonstrated in the grant from the Australian Commission on Safety and Quality in Health Care, the expectation has been that primary care will customise this work for application in primary care.

The design of the standards needs to be done in the context of the material risk to patients (and health professionals). There appears to be an increasing use of the 'precautionary principle' in standards setting in areas mentioned in the Consultation Paper (e.g. infection control). The overt or covert use of this principle needs to be carefully examined, as its application has the potential to substantially increase health care costs.

Whether or not the work is 'outsourced' or not, the role of the profession is central. The mechanism will need to be acceptable to the RACGP if it is to be supported by the RACGP.

The RACGP continues to be concerned about the disproportionate financial support for activities in the hospital sector, compared to the primary care sector. It also continues to be concerned about the low level of specific commitment to general practice by the Australian Commission for Safety and Quality in Health Care. In that context, it is difficult for the RACGP to support a standards-setting process without being concerned that general practice will continue to be marginalised.

The questions of whether or not the standards should be pass/fail, the mechanisms of compliance, and the nature and immediacy of the sanctions, all derive, substantially, from the purpose of the safety standards.

Care needs to be taken that the appropriate person is held accountable for any perceived failure to meet standards. There is a range of ownership models in Australian health care, and in some contexts, the choices of practitioners are shaped by the 'owners' of their settings. In that context, any sanctions need to be able to apply to the 'governors' of the settings, where appropriate, in addition to the health professionals who work within them.

The RACGP is aware that there will be some parties who are concerned that professional self-interest will undermine the setting of rigorous standards.

Historically, the RACGP has involved consumers and other stakeholders in the standards development process, and has provided its standards for external peer review (to the International Society for Quality in Health Care). The RACGP sees such external review as appropriate in maintaining the confidence of the public and the profession.

5. Assessment of non-clinical and technical compliance

The alternative model recognises that health services will continue to be required to comply and be assessed against jurisdictional regulation. Non-clinic and technical compliance standards will need to be identified and mechanisms developed to ensure recognition of these processes as part of a broader mutual recognition of accreditation which reduces duplication.

The Commission is seeking stakeholder input on:

- *The appropriateness and effectiveness of assessing separately non-clinical and technical compliance of a health service*
- *Timeframe for the identification of non-clinical and technical compliance requirements; and*
- *The resource implication of these changes, if any and funding options that should be considered.*

A single national approach to the safety of the Australian community, and the quality of health services cannot be achieved unless the State/Territory jurisdictions will harmonise legislation and regulation involving technical compliance with an overall patient safety strategy.

In terms of non-clinical compliance (e.g. fire safety), the RACGP takes the view that health settings should be deemed to comply with these standards; and should be

assessed in same way, and at the same rate as other settings to which these standards apply.

In terms of technical compliance, the experience of general practitioners is that legislation can lag behind best practice, and can be devised to function effectively for some stakeholders but create substantial compliance problems for general practice. Examples of this include legislation surrounding the storage and use of s8 drugs, and the requirements for waste disposal.

Additionally, advances in technology can change the parameters of the risk, making it safe to undertake some activities in general practice. This is illustrated by the advent of self-calibrating equipment for point-of-care pathology testing.

As a result, technical compliance models need to allow for easy change (e.g. through regulation, rather than legislation); and the system needs to be crafted in such a way as to minimise perverse incentives to such changes.

6. Development of a national framework for quality improvement

The alternative model proposes that a national quality improvement framework be developed for endorsement by Health Ministers and implementation by health services.

The Commission is seeking stakeholder input on:

- *The structure and content of a quality improvement framework*
- *International or local examples of a quality framework that could be considered in the development of an Australian quality improvement framework*
- *Timeframe for the development and implementation of a national framework for quality improvement*
- *The impact of these reforms on the accreditation service industry and their capacity to make the proposed changes*
- *Implementation issues that may arise; and*
- *The resource implications for development of, and compliance with, a national quality framework and funding options available.*

Medical specialist colleges appear to share a number of elements of a quality improvement framework. This has been evident in the work of the National Risk Management Working Party, which includes representatives of the Committee of Presidents of Medical Colleges, the Australian Medical Association, and the medical indemnity insurers.

The reform process could productively build on this common base.

7. Establishment of a national entity to lead and coordinate changes

The alternative model proposes that a National Entity be established to provide coordination and leadership of accreditation nationally. The National Entity will report to:

Health Ministers

Industry

Community and

The Australian Commission on Safety and Quality in Health Care in relation to safety and quality matters.

It will be manage the processes of standards development, assessment of quality assurance, monitoring and reporting.

The Commission is seeking stakeholder input on:

- *Issues that may arise in the establishment of a national entity*
- *Options for the establishment of a national entity. For example whether it should be established within an existing void, as a secretariat, or by the creation of a new body. The National Entity could operate as a statutory body, and incorporated body or as an advisory body in the way the Australian Commission on Safety and Quality in Health Care (the Commission) operates*
- *Mechanisms for ensuring stakeholder representation, particularly consumers*
- *Timeframe for the establishment of a National Entity; and*
- *The resource implication of establishing a national entity and funding options that should be considered.*

A critical question in the establishment of any national entity to lead and coordinate change is to whom the entity is accountable.

Although it has been suggested that an entity would report to Health Ministers and other stakeholders, the RACGP would like to know whether it would be accountable to the Australian Health Ministers Advisory Committee, or to (for example) the Australian Parliament.

Without some accountability to the profession, it is difficult to conceive of a model that would provide the profession with meaningful 'ownership' of the entity and influence over its direction. Without this, there is a real risk that its responsiveness to the profession would be tokenistic.

The RACGP would request clarification as to the accountabilities of any proposed new National Entity.

8. Review of surveyor training

The alternative model proposes that there be a review of surveyor training and assessment across the range of accreditation programs.

The Commission is seeking stakeholder input on:

- *The priority of carrying out such a review*
- *The scope of the review of surveyor training and assessment*
- *The timeframe for the review; and*
- *The resource implication of this review.*

Surveyor training is central to the integrity of accreditation. In that context, a review of surveyor training is important.

Despite this, surveyors are instrumental to the quality assurance and quality improvement system that is used. As a result, until the system and its requirements are clearly defined, it is difficult to justify a review of surveyor training.

Quality improvement of surveyor training should follow agreement on the national system. Arguably, in the medical crafts, it should also follow the mapping and rational of standards and accreditation systems.

9. Associated reforms

In addition to the changes in the alternative model there are a number of reforms that could be progressed as part of the implementation of broader reforms or as separate projects, as described above. These include:

- *Using unannounced surveys to assess the national minimum safety standards (after appropriate piloting)*
- *Pilot tracer methodology (patient journey)*
- *Developing a best practice guide to standards development and review*
- *Mapping of standards*
- *Developing appropriate mechanisms, timing and format for public reporting; and*
- *Developing a process for mutual recognition of accreditation processes and outcomes.*

The Commission is seeking stakeholder input on:

- *The priority of carrying out each of these proposals*
- *The scope of each of these proposals*
- *The timeframe for the implementation of each of the proposals and*
- *The resource implication of the proposals.*

The RACGP would support an appropriately funded activity that aimed to map standards and develop a process for mutual recognition of standards and accreditation processes across the specialist medical colleges. The RACGP would support a related process that assisted in developing a 'best practice' approach to standards development and review; and for the development of mechanisms for public reporting of achievement of standards.

The RACGP is confident that sound progress could be made within the specialist medical colleges if such an activity were funded; and the RACGP would be prepared to lead such an activity.

The use of unannounced surveys presents a major change to the current accreditation model. The RACGP, as has been outlined previously, has reservations about a system that would be grounded in cyclic accreditation for some settings, and unannounced/random visits as an alternative, for others. In that context, the RACGP sees this is a lesser priority.

The RACGP also sees the introduction of tracer methodology (patient journey) as a lower priority. The potential for introducing this should follow more detailed discussion and observation of the methodology. It is also likely to be easier to introduce if there is harmonisation of standards, and if all settings have some form of accreditation.

Conclusion

The RACGP sees some merit in a number of the options provide in the Consultation Paper. It takes the view that substantial progress could be made by building on existing strengths in the standards setting and accreditation system, especially those evident amongst specialist medical colleges.

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