### Consultation paper – Patient Safety and Quality Improvement in Primary Care

**Brisbane South Primary Health Network Submission**

| Question 1 | The scope of primary care services as the focus for the Commission’s program of work.  
The consultation paper defines primary care services as:  
‘services provided by general practitioners, practice and community nurses, nurse practitioners, allied health professionals, midwives, pharmacists, dentists and Aboriginal and Torres Strait Islander health practitioners either, in the home, general or other private practice, community health services and local or non-government services’.  
1.1 Do you consider this to be an appropriate definition of primary care?  
1.2 Should this definition be amended? If so, what should be addressed in an alternative definition of primary care? |
|---|---|
| Response 1 | 1.1 **Do you consider this to be an appropriate definition of primary care?**  
The definition is a good starting point but could be enhanced. It is good to see a broader definition of primary care, not just general practice. It may be unwise to name professions in the definition given the danger of omission. Other groups such as peer support workers need to be covered by the definition.  

1.2 **Should this definition be amended? If so, what should be addressed in an alternative definition of primary care?**  
The following definition developed by the Australian Primary Health Care Research Institute (APHCRI) is proposed for consideration as an alternative:  

‘Primary health care is socially appropriate, universally accessible, scientifically sound first level care provided by health services and systems with a suitably trained workforce comprised of multi-disciplinary teams supported by integrated referral systems in a way that: gives priority to those most in need and addresses health inequalities; maximises community and individual self-reliance, participation and control; and involves collaboration and partnership with other sectors to promote public health. Comprehensive primary health care includes health promotion, illness prevention, treatment and care of the sick, community development, and advocacy and rehabilitation’.  

Should the commission decide to amend the consultation paper definition consideration should be given to including reference to:  
- Health promotion, illness prevention, health maintenance, health education and continuity of care in the diagnosis and treatment of acute and chronic illness  
- Acknowledging the impact of social determinants on primary care access, participation and outcomes  
- Addressing needs of patients from culturally and linguistically diverse backgrounds |
| Question 2 | Safety and quality issues in Australian primary care services.  
2.1 What are the safety and quality issues experienced by you, your primary care service or the primary care services you support?  
2.2 What strategies have been implemented to address these? Have these been evaluated?  
2.3 Have you noticed any changes in the quality of the service you receive or provide?  
2.4 What additional strategies, tools or resources should be developed and/or made available to make these strategies more effective? |  
|---|---|  
| Response 2 | 2.1 What are the safety and quality issues experienced by you, your primary care service or the primary care services you support?  
The following issues were raised by members of the Brisbane South PHN Clinical Advisory Council and workforce  
- Australia’s primary health care, as small businesses, contributes to some of the issues related to safety and quality in the primary health setting  
- New graduates (especially from the non AHPRA regulated professions) going into sole trader or contractor roles may impact on quality and safety  
- There is no uniform system for recording or reporting clinical incidents that occur in primary care within and across practices  
- There are inconsistent practices, knowledge and understanding of the importance of addressing and managing safety and quality issues within practices  
- Lack of communication among different primary care professionals and with other parts of the health system  
- Communication modes are not always secure (eg email of patients details between health professionals)  
- Not having access to a full patient record including medications and allergies, especially when undertaking home visits – extra time may be required to follow up and this can impact on quality  
- The lack of efficient and effective handover in residential Aged Care Facilities may mean important clinical information from the GP is not clear to staff on later shifts  
- The lack of appropriate language/translation services for CALD patients in other parts of the health system can impact back on primary care (eg when discharge instructions and medication instructions are not understood by the patient)  
- Lack of capacity to backfill staff absences; old, slow computer equipment etc can impact on efficient care and quality  
- Dealing with uncertainty and medically unexplained symptoms  
- The complexity of the health system can lead to unintended consequences when new strategies/protocols are implemented  
- CALD patients accessing generic medications may overdose themselves if they don’t realise that the new script is the same compound as the old – |
just with different packaging and name.

- Primary care providers may have to deal with adverse events related to/following hospitalization

2.2 What strategies have been implemented to address these? Have these been evaluated?

- Strong practice nurse support is essential for quality and safety. They can develop protocols, oversee implementation of guidelines such as handwashing, respond to issues raised by patients about their GP care, provide a link between the GPs and practice administration
- My healthcare record aims to address communication issues but has not been evaluated fully at this stage
- Incident logs which include evaluation and learning points from the incident
- Secure messaging with GP access to the health provider portal (Viewer) to access patient hospital records across QLD
- The Brisbane South PHN works with the HHS and primary care to support quality improvement initiatives within primary care (including clinical handover, developing and educating nurses new to general practice, working with practices to examine their data and identify key areas for quality improvement)
- Health Care Homes readiness – supporting primary care to enhance management of patients with complex and chronic disease through leadership, workforce development, data quality and consumer health literacy support and self-management
- Yellow envelope - clinical handover between aged care and emergency department

2.3 Have you noticed any changes in the quality of the service you receive or provide?

- With certain services (such as webster packs) use of procedures and technology (such as virtual dispensaries and scanning each med when packing) has reduced the error rate
- Australian Primary Care Collaboratives showed improvements in systems and adherence to clinical guidelines in general practice. Through collaboratives and quality improvement initiatives there has been adherence to clinical guidelines as a result of greater knowledge of guideline content. Identification of patients requiring follow up has improved through increased knowledge and
2.4 What additional strategies, tools or resources should be developed and/or made available to make these strategies more effective?

- Many of the safety and quality issues in the delivery of primary care sector are directly impacted by other issues that fall under the social determinants of health. Addressing the social determinants in an integrated fashion will assist in delivering care that is both safe and of quality.
- Similarly improvements to accessing and navigating ‘My Aged Care’ will assist primary care providers in delivering the best quality care to their older patients.
- The new quality and safety in primary care guidance needs to build on and dovetail with existing tools including the Quality Use of Medicines.
- Consultation with CALD communities and having alternatives to English only on-line sources of information can improve quality and safety outcomes.
- Developing a user-guide for the standards to address the CALD community issues.
- Encouraging minimal health datasets to include language spoken, country of birth and ethnicity as well as year of arrival in Australia is essential to having useful and accurate data that enables services to be crafted to the needs of the community.
- Develop a parallel document that focuses on health professional health to ensure that it both recognizes that health professional health is a quality indicator for the delivery of quality care and also enables health professionals to justify prioritizing their health to ensure they can deliver health care safely and effectively.
- Undertake more research to assist with understanding variation of care and build better datasets before using variation in primary care as a reliable quality indicator.
- Secure messaging for all health professionals such as medical object to be used by everyone. More real-time access to patient summary and notes.
- Integrated referral management system – increasing digital connectivity to enhance safe and timely transfer of patient information.
- Develop a reporting register for safety and quality issues with primary care.
- Effective and consistent governance process for primary care.
- Development of a suite of templates to support safety and quality initiatives.

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<td>How could the Commission address these?</td>
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<td>3.4</td>
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3.1 What are the barriers and enablers for implementation of these standards in primary care?

**Barriers:**
- Many primary care providers operate in private practice as sole traders or small businesses. There is variability and capability in solid business acumen and leadership (with greater focus on seeing the patient) and they can be time poor and low on resources. The standards framework needs to be adaptable to sole traders who provide services direct to the public or under contract through a health service that may or may not have its own accreditation as well as practitioners who practice as part of a small or large multidisciplinary practices, with one or more regulated health service on a contractual basis
- The complexity of the primary care sector
- Lack of understanding about existence and ways to implement standards
- Lack of interpreter access for all primary care providers
- Lack of datasets that capture minimum data

**Enablers:**
- Existing national quality frameworks such as those for mental health (which apply in primary health care) provide a foundation to build on.
- Existing quality frameworks already implemented by professional groups will also have paved the way for the Commission’s Standards
- An incentive similar to PIP could include report writing time, secure messaging assistance and access, case conferencing time with the multidisciplinary team
- To keep the quality framework reasonably straightforward and affordable and feasible for small businesses to implement

3.2 How could the Commission address these?
- The commission will need to undertake extensive consultation with providers and deliver an awareness raising, communication program about standards to each primary care organisation

3.3 What support could other organisations provide for implementation?
- PHNs could support implementation of standards, and undertake consultation with local primary care providers to determine priorities for local rollout if sufficiently resourced
- Hospital and day surgery workers that know more about implementation of standards could offer advice/learnings
- Professional groups with existing quality frameworks would need to align with the Commission’s standards.

3.4 Which organisations need to be involved in this process?
- Primary Health Networks (PHNs)
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<th>Question</th>
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**Response 4**

4.1 What are the barriers and enablers for the review process, development and implementation of indicators in primary care?

**Barriers:**
- Small business/private practice based on altruistic intent rather than solid business acumen
- Information and tools already exist but are not adequately promoted, which means there is limited awareness and uptake
- Limited participation by practice and practitioners
- Measurement of accessibility would need to cover physical access as well as cultural and language access
- Measures of coordination and continuity of care are difficult to attribute only to primary care
- Patient participation indicators will be difficult to improve without real investment in translation support

**Enablers:**
- Need to develop a ‘no blame’ culture which encourages the reporting of errors/nears misses (like the NHS for example).

4.2 How could the Commission address these?

- Very clear explanation for reasons for review process, development and implementation through written material and also presentations
- Some financial incentives for practices although not all practices are accredited currently so incentives aren’t always the enabler
- Making it mandatory

- Doctor/General Practitioner peak body/associations; accrediting bodies (AMA, RACGP, AGPAL)
- Nurse peak bodies/associations (APNA, Midwife association/registration body)
- Australian Association of Practice Managers (AAPM)
- Allied Health peak bodies/associations
- Pharmacy Guild
- Aboriginal and Torres Strait Islander health peak bodies/associations (ACCHO)
- Australian Health Practitioner Regulation Agency (AHPRA)
- Health Consumer groups
• Offering training and education
• Quality and safety component built into university courses

4.3 Which organisations should be involved and what is their role?
• Organisations which represent health professionals for indemnity insurance could possibly supply de-identified data
• RACGP and ACRRM, pharmacy, dental and other allied health organisations could support, promote, educate, build capacity, develop resources
• PHNs could support, promote, educate, build capacity
• University and training organisations to include safety and quality components within core subjects

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<td>• Some practices have a recall service, clinical case meetings to discuss cases and incidents</td>
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<td>• Service commissioned by the PHN are required to demonstrate adequate clinical governance arrangements</td>
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| 5.2 What strategies, tools or resources to support improvements in safety and quality should be considered? |
| The following are in addition to those provided in the previous responses: |
| • Clinical networks, communities of practice, information and education, promotion of pertinent issues, healthpathways, accreditation support, QI program areas |
| • Better minimal datasets in primary care software (including CALD communities) |
| • Case studies, recall service, feedback system beyond individual practices |
| • Feedback system and better communication system among different primary |
5.3 What safety and quality strategies, tools and resources can be led by the Commission in a national approach?
- Develop the framework, make it mandatory and fund it. Ongoing review and monitoring to adapt as necessary
- Development of tools to support continuity of care and communication facilitation in a multidisciplinary care team environment
- Provide guidance for adverse event reporting
- The electronic health record should be an integral part of any plan to improve safety and quality in health - so the Commission’s Standards and tools would need to fully integrate with the EHR and also the separate software providers.

5.4 What safety and quality strategies, tools and resources can be led by professional support organisations?
- Support, promote, build capacity, develop localized resources to support the rollout and ongoing monitoring

5.5 What are the barriers and enablers for implementation of these?
As above

5.6 How could the Commission support implementation of these?
As above

5.7 Which organisations need to be involved in the process and what is their role?
As above