Submission on

Patient safety and quality improvement in primary care
Consultation paper

21 December 2017
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ABOUT RDAA

RDAA is the peak national body representing the interests of doctors working in rural and remote areas and the patients and communities they serve.

RDAA’s vision for rural and remote communities is simple – excellent medical care.

This means high quality health services that are:

- patient-centred
- continuous
- comprehensive
- collaborative
- coordinated
- cohesive, and
- accessible

and are provided by a GP-led team of doctors and other health professionals who have the necessary training and skills to meet the needs of those communities.

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INTRODUCTION

RDAA is supportive of measures that work to improve the quality of care for and safety of patients throughout the entirety of primary care services, recognising this focus is necessary to ensure best practice, and welcomes the opportunity to make a submission to the Australian Commission on Safety and Quality in Healthcare (the Commission) on its consultation paper, *Patient safety and quality improvement in primary care*.

In rural and remote areas the degree of isolation and other geographic, climatic, socio-economic, demographic and cultural factors impact on the provision and cost of health services and significant inequities of access to health care exist. Primary care is often more closely interlinked with secondary care than in urban settings.

That variations in access to health professionals and services and patient outcomes exist in rural and remote areas is recognised within the consultation paper. It is important therefore that any measures to improve safety and quality of care for patients are designed with due consideration of the impact on rural and remote doctors and people. The complex intra- and inter-dependent nature of primary and secondary healthcare in rural and remote areas must be recognised and reflected in safety and quality standards, guidelines and indicators.

All standards, guidelines, indicators, processes (including peer review) and requirements, must be “rural and remote friendly”. They must be developed with appropriate rural and remote input and with the clear understanding that the availability of human, physical and capital resources in rural and remote communities is variable.

RDAA has identified some key issues for consideration.
Defining primary care services

The definition of 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’, while identifying the health practitioners that may be involved and settings where care may take place does not give an indication of what primary care services actually are.

Primary care services are diverse, spanning prevention, diagnoses, treatment and management of a range of episodic and chronic conditions across the life span of patients. These services are primarily provided and coordinated by General Practitioners (GPs). Consulting a GP is the most common action related to health care undertaken by Australians.

Ensuring that the GP is at the centre of all primary healthcare arrangements and supported to provide coordinated, patient-centred, team-based, comprehensive continuity of care for their patients is critical to the provision of high-quality and safe health care. It is a model that promotes and facilitates collaborative approaches and provides the most appropriate, community-based, cost-effective care for rural and remote Australians.

National Safety and Quality Health Service (NSQHS) Standards for primary care services other than general practices should not be developed in isolation from general practice. In rural and remote communities primary care services provided by other health professionals often take place within the practice or under the supervision of the GP. They therefore bear ultimate responsibility for safety and quality. GPs are also often the referrers or coordinators of such care.

- Rural and remote GPs, and their representative organisations, must be consulted about the development of nationally consistent safety and quality standards and indicators for primary care services as a whole as they are the cornerstones of primary care.
The national context

Australia is currently undergoing numerous changes to the ways in which the health system is funded and health services delivered. In rural and remote areas the level of funding allocated these initiatives, and to the training, recruitment and retention of health professionals, is a critical factor in effectively addressing the inequities of access and patient outcomes that exist, and improving safety and quality in primary care in these areas.

The development of patient safety and quality measures must be cognizant of these changes. Safety and quality standards, guidelines and indicators will be pertinent to these initiatives and should inform the development, establishment and operation of resulting programs.

- Safety and quality standards, guidelines and indicators must inform, and be informed by, other national health initiatives, such as Health Care Homes, throughout their development and implementation.

Existing arrangements

GPs in rural and remote general practices operate under considerable work-related and personal pressures. They often provide services at home or in residential care facilities as well as in the general practice setting. They may also provide on call services and be on emergency, clinic or service (for example in obstetrics and/or anaesthetics) rosters at the local hospital. These GPs must make higher-level clinical decisions and take greater responsibility when working in isolation where there are few professional supports, and limited diagnostic services and other health facilities. In addition to providing these services for patients, rural GPs may also teach or supervise medical students or junior doctors and be practice owners with all the responsibilities this entails, including for staff management. They are often time poor.

GPs and their practices are already subject to multiple credentialing and accreditation processes by multiple state, national and/or international organisations for safety and quality purposes. These processes are often onerous. They generally require the same information and involve considerable time and effort. They can by their very nature be a disincentive for doctors to undertake the necessary steps to achieve accreditation. There
are a number of general practices in rural and remote Australia that are not accredited by recognised national organisations.

- Existing multiple professional and practice accreditation processes are already contributing to significant imposts on time. They should be streamlined to avoid unnecessary repetition of information and duplicative effort. Information should be held in a secure repository and, with the consent of the GP, made available to credentialing and accreditation bodies.

- A robust and streamlined approach across primary care services, which recognises that, in rural and remote areas, the GP is the primary provider and coordinator of all primary care services, and that these services are closely linked to secondary care processes, is necessary to avoid unnecessary time and other imposts and duplication of information.

The role of governments in primary care

As has been recognised, limitations and deficiencies with existing physical infrastructures can impede the delivery of better primary healthcare, particularly in rural areas where concerns about recouping the cost of an investment in infrastructure and achieving capital growth can deter doctors and practices from privately funding the enhancement and extension of premises and facilities.

In some rural and remote areas it may be necessary for federal, State/Territory or local governments to support the provision of high-quality and safe primary care services. In some areas of “market failure”, where private general practice has become unviable, State/Territory governments have already been called upon to intervene and provide primary care services.

- Attention must be given to the role of Governments in primary care when developing standards, guidelines and indicators for safety and quality improvement in primary care.

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Addressing unwarranted health care variation and specific safety and quality risks in rural and remote primary care

While the clinical areas list provided on page 19 of the consultation paper appears to align with current areas of focus and identified risk for primary care setting, some additional consideration may need to be given to ensure that recommendations are mindful of the rural and remote context where implementation of recommendations may be more problematic.

Other specific primary health care activities and protocols must also be reviewed to ensure that they are in the best interests of the patients and that inflexibility does not compromise patient safety or the safety of doctors and other health care professionals and staff.

- Nationally consistent guidelines for the management and transfer of aggressive and violent patients should be developed. Current protocols vary between States and Territories.

- Consideration must also be given to protocols governing the transfer of aged, demented and/or palliative care patients to distant facilities sometimes along winding or otherwise difficult roads. Such transfers are likely to cause significant distress to the patient as well as possible physical harms.

Incident reporting

As acknowledged in the consultation paper, general practice accreditation requires the implementation of clinical risk management systems but that information is not always widely shared. It should be noted that not all general practices in Australia are accredited and that, in an increasingly litigious society, there is a significant disincentive to report incidents.

For reporting systems to be of value they must be linked to clear governance processes and safety and quality improvement measures within the primary care service. Consideration must also be given to what mechanisms, such as de-identification processes, would best facilitate inclusion of all primary care services and the broader use of such information to inform safety and quality.