Practice-level indicators of safety and quality for primary health care

SYNTHESIS OF SUBMISSIONS ON THE CONSULTATION PAPER AND RECOMMENDED NATIONAL INDICATOR SET
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GLOSSARY

Acceptability

The care/service provided meets the expectations of the client, community, providers and paying organisations, recognising that there may be conflicting or competing interests among stakeholders, and that the needs of the clients/patients are paramount. [1]

Accessibility

Clients/patients can obtain care/service at the right place and the right time, based on respective needs. [1]

Appropriateness

The care/service provided is relevant to the clients/patients' needs and based on established standards. [1]

Coordination of care

Coordinated use of other levels of health care. [2]

Continuity of care

Uninterrupted, coordinated care/service across programs, practitioners, organisations and levels of care/service over time. [1]

Dimensions of quality

Notion popularised by the US Institute of Medicine in Crossing the quality chasm. [3] The usual six dimensions of quality are safety, effectiveness, appropriateness, consumer participation (or acceptability), access and efficiency. [4]

Effectiveness

The care/service, intervention or action achieves the desired results. [1]

Practice-level indicators of safety and quality for primary health care

Measures or markers of quality of care that should be generated and reviewed routinely by primary health care providers at the service unit, practice or local level. [Australian Commission on Safety and Quality in Health Care]

Quality indicators

Succinct measures or markers of quality of care. [Australian Commission on Safety and Quality in Health Care]

Safety

Potential risks of an intervention, or the environment, are avoided or minimised. [1]
1. Introduction

1.1 Background

The Australian Commission on Safety and Quality in Health Care (the Commission) was established by Australian Health Ministers to lead and coordinate improvements in safety and quality in health care at a national level. Under the National Health Reform Act 2011 (http://www.austlii.edu.au/au/legis/cth/consol_act/nhra2011216/), the Commission is required to develop indicators relating to healthcare safety and quality.

Before formulating standards, guidelines or indicators, the Commission must, under the Act, consult:

- clinicians
- bodies known as lead clinical groups
- heads of states’ and territories’ health departments
- any other persons or bodies who, in the Commission’s opinion, are stakeholders in relation to the formulation of the standards, guidelines or indicators
- the public.

The Commission follows a consistent process for identifying and selecting national sets of safety and quality indicators (for further information about this process, see Appendix 1).

1.2 Project purpose and scope

The purpose of this project is to:

- research the context for improving safety and quality in primary health care, and identify practice-level indicators currently in use
- develop a candidate set of practice-level indicators of safety and quality for primary health care, in consultation with relevant individuals and organisations
- obtain endorsement for the national set of practice-level indicators of safety and quality for primary health care
- develop a specification for the national set of practice-level indicators of safety and quality.

‘Practice level’ refers to organisations, teams and individual practitioners providing primary health care services. Recommendations regarding indicators for general practice are not in this project’s scope for the outcomes. The Royal Australian College of General Practitioners (RACGP) is conducting a dedicated project to develop indicators for general practice.

Safety and quality practice-level indicators are measures or markers of the quality of care delivered by primary healthcare providers at the service unit, practice or local level. Practice-level indicators are intended to support continuous quality improvement through monitoring of trends over time, and to identify issues or significant variances in one or more dimensions of quality of care. These indicators should be generated and reviewed routinely by providers at the local level.

The national set of practice-level indicators of safety and quality will be designed for voluntary inclusion in quality improvement strategies at the local practice or service level. It is intended that primary health care services will choose a ‘local bundle’ of indicators from the national
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Indicator set as a tool to assess and monitor the service’s improvement in different dimensions of quality, and particular aspects of care, pathways or conditions. The components of a local bundle of indicators may vary over time, depending on local circumstances, priorities for quality improvement, patient needs, and concurrent state and national reporting obligations applicable to the service.

Note: The term ‘patient’ has been used to denote ‘patient/client/consumer’ for ease of presentation in this paper. The exception is when information has been taken from another source.

1.3 Consultation processes

The eHealth Services Research Group (eHSRG) from the University of Tasmania was engaged to undertake research and conduct initial consultation with peak and expert groups, including two focus groups held in March 2011.

The literature review and environmental scan completed by eHSRG informed the development of a Consultation Paper and the candidate set of indicators. [5] Further consultation in 2011 was conducted by the Commission with representatives of stakeholder groups to develop the candidate set of indicators.


Feedback from the consultation has informed the development of the national set of practice-level indicators of safety and quality.

See Appendix 4 for details of organisations and individuals involved in the consultation processes.

1.4 Purpose of this report

The purpose of this report is to provide:

- a synthesis of responses received on Practice-level indicators of safety and quality for primary health care: Consultation Paper 2011.

- the recommended national set of practice-level indicators of safety and quality for primary health care
2 GUIDING PRINCIPLES — PRACTICE-LEVEL INDICATORS OF PRIMARY HEALTH CARE

The guiding principles aim to:

- set out the Commission’s approach to practice-level indicators of safety and quality for primary health care
- provide guidance on the selection of practice-level indicators of safety and quality for primary health care
- inform health professionals and service providers in designing and undertaking practice-level quality improvement activities.

The guiding principles are as follows:

1. Practice-level indicators of safety and quality for primary health care are intended for voluntary use in quality improvement strategies at the local practice or service level, and are not designed to serve as performance indicators.

2. ‘Quality is complex and multidimensional. No single group of indicators is likely to capture all perspectives on, or all dimensions of, quality.’ [7] Services should choose a local bundle of indicators from the national set of practice-level indicators of safety and quality to support their focus on certain dimensions of quality, a range of process and outcome measures, and particular aspects of care, pathways or conditions.

3. The components of the local bundle of indicators will vary over time, depending on local circumstances, priorities for quality improvement, patient needs and the service’s scope of practice. (Note: Information on how services construct and use these bundles should be provided as part of the implementation strategy for the national set of indicators.)

4. State and national reporting obligations, as well as the local scope of practice, will determine which other specific clinical, professional and health service standards and indicators are also applicable to the practice or service.

5. Practice-level indicators of safety and quality should be:
   - clearly defined
   - supported by a clear rationale
   - achievable and relevant for primary health care practice
   - easily collected, preferably from existing datasets
   - reliable and valid
   - attributable to actions in primary health care
   - free from obvious unintended consequences.
6. The national set of practice-level indicators of safety and quality for primary health care should reflect:

- that safe and high-quality care is consumer centred, driven by information and organised for safety [8]
- the significance of the communications between healthcare providers involved in a patient’s care [9]
- the defining characteristics of primary healthcare practice as identified by Starfield: [10]
  - first-contact care
  - person-focused care over time
  - comprehensive care
  - coordinated care.

7. The national set of practice-level indicators of safety and quality for primary health care should:

- cover those aspects of primary health care and patient issues that are broadly applicable across settings, disciplines and geographic locations
- consist of a core set of indicators of safety and quality that every practice or service can use.
3 BEST PRACTICE IN PRIMARY HEALTH CARE

The Commission’s research and consultation process identified some elements of best practice in primary health care, which suggests that these should be measured in practice-level quality improvement activities, where practicable. These elements include, but are not limited to the following:

- Health professionals should use the best available evidence to inform their clinical practice (NSQHS Standard 1).
- Care provided by the clinical workforce is guided by current best practice, as agreed by the appropriate body (NSQHS Standard 1).
- Over time, the characteristics and social determinants of health of the local community/service population should be identified, reported and analysed to inform service planning and quality improvement.
- The service is able to demonstrate effectiveness of clinical treatment using outcome measures.
- The service is able to demonstrate evidence of providing appropriate coordinated care to ensure that patients are guided through the correct care pathway, and attend the most appropriate service providers in the most appropriate timeframe.
- Patient safety incidents are recognised, reported and analysed, and this information is used to improve safety systems (NSQHS Standard 1).
- Patient rights are respected and their engagement in their care is supported (NSQHS Standard 1).
- Patients and carers are supported by the health service organisation to actively participate in the improvement of the patient experience and patient health outcomes (NSQHS Standard 2).
- The service should support a collaborative approach to service delivery.
- Patients should receive a complete assessment, considering all relevant health issues, at the beginning of every episode of care and this should be reviewed each year.
- Care plans and care coordinators should be in place for all patients with multiple or complex needs, such as chronic conditions.
- Strategies for the prevention and control of healthcare associated infection care are developed and implemented (NSQHS Standard 3).
- The clinical workforce accurately records a patient’s medication history and this history is available throughout the episode of care (NSQHS Standard 4).
- Referral processes, clinical handover processes, and transfer of information between health professionals and services should support effective continuity and follow-up of care.

These elements of best practice have guided the selection of the candidate indicator set. Some elements are already included in the National Safety and Quality Health Service Standards (as noted), and to avoid duplication, were not included in the candidate set. Other elements have been incorporated in the candidate set of indicators for primary health care (set out in Section 7).
4 GENERAL COMMENTS

All comments included below are direct quotations from submissions received in the public consultation held during September to October 2011. The Consultation Paper and submissions are available at http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/PriorityProgram-08_PracticeLevelIndicators

4.1 Support for the proposals in the consultation paper

- ‘The intent to develop a set of indicators relating to healthcare safety and quality is a positive step forward and is supported.’ (Queensland Health)

- ‘GPN supports, in principle, the concept of developing a set of practice-level indicators for primary health care (PHC) practices which can be voluntarily adopted as an aid to implementing practice improvement strategies and policies.’ (AGPN)

- ‘The Royal College of Nursing Australia (RCNA) believes that a set of established practice-level indicators developed by a national authority on which to base standards and guidelines for primary health care practices will be of great benefit to the broad range of community and primary health care nursing services.’ (RCNA)

- ‘Services for Australian Rural and Remote Allied Health (SARRAH) applauds the work done by the Commission for working to create standards for all primary health care services.’

- ‘It was generally considered that the indicators developed seem very appropriate to the Health Directorate and will be very helpful in establishing and monitoring standards in ACT Community Health Centres.’ (ACT Health)

- ‘The practice-level indicators hold relevance in the context of a dental practice. Almost all of the practice-level indicators have potential to assist a dental practice in the monitoring of safety and quality matters.’ (Dr Murray Thomas)

- ‘The Dietitians Association of Australia (DAA) supports the guiding principles for practice-level indicators of primary health care, and the dimensions for categorising candidate indicators.’

- ‘These indicators will provide primary health care in Tasmania with an effective framework to assist in the monitoring of quality and safety within the service environment.’ (Department of Health and Human Services Tasmania)

- ‘The document provides a sound basis for guiding primary care organisations in practice-level indicators which will help them with continuous quality improvement activities.’ (Professor Michael Greco, Director, CFEP Surveys)

- ‘The Association applauds the model of primary health care delivery proposed.……This represents a conceptual paradigm shift and lays out a visionary integrated model of health care that is founded in the literature and focuses primarily on patient care and need. The move from a disease-based model of care to one based on a holistic understanding of the patient’s overall healthcare needs is exemplary.’ (ACPA)

- ‘The proposed list of candidate practice-level indicators outlined in the consultation paper provides a sound platform for the development and implementation of a
national set of safety and quality indicators for primary health care (beyond general practice).’ (National Heart Foundation of Australia)

- ‘It is essential that there are thorough and appropriate measures of quality to ensure consumers are receiving the best, most clinically appropriate services, and to drive quality improvement within primary care services.…… [CHF] supports the proposed model in which …..services choose a local bundle from a national set of indicators, which is able to vary over time.’ (Consumers Health Forum of Australia (CHF))

- ‘The Royal Australian College of General Practitioners (RACGP) welcomes and recognises the need for practice-level indicators in the delivery of healthcare in Australia. …As the Commission has noted, indicators for general practice have been excluded as the RACGP is currently developing indicators for general practice. The RACGP concurs that practice-level indicators should be intended to support continuous quality improvement….supports voluntary inclusion by providers in quality improvement strategies at the local practice or service level and given the diversity of primary healthcare providers, the flexibility for providers to choose a local bundle of indicators is paramount. The College agrees that practice-level indicators should not be developed to serve as performance indicators……The College recommends that indicators be evidence based…..documented evidence does not always exist, and where this happens, the indicators should be recommended on the opinion of respected authorities based on clinical experience.’(RACGP)

- ‘The capacity for a service to voluntarily select a varying ‘bundle’ of a small number of indicators to implement at any one time enables the focus on safety and quality to be an ongoing integrated element of service delivery……. The flexibility of implementation of the indicators is a marked strength of the proposal.’ (Australian Clinical Psychological Association (ACPA)

- ‘The concept of a service using a suite of indicators relevant to that service is worthwhile.’ (Philippa Cahill, Service Manager Palliative Care, SESIAHS)

- ‘I am delighted to see a comprehensive approach to measuring the quality of care in primary health care….I strongly support the collection of data as a practice-wide unit as it will increase the focus of quality within practices and move the focus away from individual doctors to the practice-wide multidisciplinary teams that will be needed to deal with the complex chronic diseases that are increasingly and becoming an huge part of primary health care.’ (John Stafford)

- ‘The Department of Health, Victoria will continue to collaborate with the Commission to maximize synergies in the developmental work going forward with the introduction of indicators in primary health, will advocate for the adoption of those national indicators relevant to community health services (CHSs) and reserves the right to adopt definitions of indicators that reflect its policies for CHSs.’ (Department of Health, Victoria)

- ‘The significance of good clinical governance in primary care has emerged as a significant issue within the consultation process for the primary care strategy for Western Australia and thus this work around practice level indicators is timely and welcome.’(Primary Care Network, Department of Health WA)

- ‘The Health Quality and Complaints Commission (HQCC) supports the role taken by the Commission in identifying and developing indicators of safety and quality for practitioners providing primary healthcare services throughout Australia…agrees with the guiding principles that indicators are intended for voluntary use in the local implementation of quality improvement strategies.’ (HQCC)
Synthesis of submissions on the consultation paper and recommended national indicator set

- ‘The Victorian Healthcare Association (VHA) supports the creation of a national set of practice-level indicators to assist primary and community healthcare services in the delivery of high quality healthcare services. Indicators are a key aspect of clinical governance arrangements within healthcare settings to ensure safe, high-quality health services are delivered to consumers… The VHA supports the Commission’s recommendation that services do not adopt every indicator, but select a ‘local bundle’ of indicators from the national set that suits their needs….. The proposed indicator set provides a good range of system and process indicators of primary healthcare direct service delivery.’ (VHA)

- ‘Inner South Community Health Service (ISCHS) believes that these recommendations, if adopted, will lead to a set of practice-level indicators of safety and quality for primary health care that are widely applicable and will support Primary Health Care organisations to better address quality and safety in a best practice framework.’ (ISCHS)

- ‘The candidate indicators appear to address appropriate key dimensions of safety and quality.’ (NSW Health)

- ‘There was strong support for structuring the indicators around the seven dimensions of quality. General practice network south (gpns) strongly supports the Commission undertaking this work’. (gpns)

4.2 Concerns with the proposals in the consultation paper

4.2.1 Scope - public and private sector?

- ‘It may not be understood that in rural and remote areas of Queensland, the public hospital system is largely engaged in primary health care activities, indeed in many communities, Queensland Health is the sole health provider. It is unclear if the indicators are even intended for use by public sector providers.’ (Queensland Health)

Response: Future documentation regarding the national set of practice-level indicators of safety and quality should state that the indicators are intended for use in both public and private health service organisations.

4.2.2 Focus – too clinical?

- ‘As a general comment, and from a community health perspective, I found the paper overly focussed on “the clinical”.’ (Doug Stevenson, Director, Southern Fleurieu Health Service, SA Health)

- ‘The categories of candidate indicators are good but the indicators themselves are very clinically focussed…… the set of indicators has a bias towards general practice rather than the many other areas that are within primary health care.’ (SA Health)

- ‘These fit with a fairly traditional approach of a community care service, not necessarily a community / primary health care approach.’ (CRANAplus)

- ‘Some indicators seemed far more relevant to general practice than other primary care practice, despite the fact that they were meant for professions other than general practice….. For example, ‘timely review of diagnostic results’ was not seen by pharmacists as relevant terminology,…..usually only a GP, Pharmacist or perhaps a Nurse Practitioner would undertake a [medication review] . . . Some of the indicators may not be relevant for all. …The worked example was far more relevant to general practice than to other primary health care providers.’ (gpns)
Synthesis of submissions on the consultation paper and recommended national indicator set

• ‘The consultation paper assumes that all or most primary health care services are directly Medicare funded but this is not true. The majority of primary health care services are provided by state managed public sector employed Allied Health Professionals.’ (SARRAH)

• ‘There is an unintended consequence of the practice-level indicators of safety and quality in primary health care for entrenching the status quo. The document is laced with terms, concepts and phrases that assume General Practitioners are the entry point and gateway to the health care system.’ (SARRAH)

• ‘The current language used within the Consultation Paper is medico-centric and does not meet the needs of all primary health care providers. (Australian Psychological Society.’ (APS))

• ‘The indicators are generally doctor-centric and not suitable for health practitioners that operate outside the traditional practice model, resulting in few indicators that would be adaptable for pharmacy practice at the primary health care level. …The paper and resultant candidate indicators do not reflect the Government’s focus on broader health reform through integrated models of primary health care.’ (Pharmaceutical Society of Australia(PSA))

• ‘The candidate indicators as they are presented in the consultation paper do not adequately address key areas of comprehensive primary health care including health promotion, prevention and early intervention which are critical to a quality primary health care system.’ (ISCHS)

• ‘The indicators appear, in the main, to be mostly focused on medical practices. We suggest additional indicators are added or that indicators are re-worded to reflect the broader range of primary health care professionals and settings involved in delivering care. These settings should include allied health, pharmacy and community settings in which a variety of community health workers deliver health education, counselling and prevention measures.’ (AGPN)

Response: Future documentation regarding the national set of practice-level indicators of safety and quality should clarify that some indicators may not be applicable to some primary health care services. Descriptions for some indicators should be reworded to reflect their broad applicability across settings and disciplines.

4.2.3 Excluding general practice?

• ‘Excluding this sector [general practice] from the development of indicators of primary care is problematic.’ (Medicare Local ACT)

• ‘The separation of general practice from this process seems out of step with the strategic direction of primary care as outlined in the Commonwealth Primary care strategic documents and will be similarly out of step with the WA emerging strategy…Quality and safety standards should be uniform across primary care and the practice level indicators applicable to all.’ (Primary Care Network, Department of Health WA)

• ‘General practices are an integral, and, in some cases, pivotal aspect of primary health care. The exclusion of indicators for general practice (of which the RACGP is conducting a dedicated project), as outlined in the Consultation Paper, is of concern. The APS hopes that any practice level indicators developed as part of this Consultation Paper will be consistent with the RACGP Standards.’ (Australian Psychological Society)
Synthesis of submissions on the consultation paper and recommended national indicator set

- ‘The exclusion of general practice from the scope of this project is of concern to RCNA. There are many nurses who work in general practice and given the need for integration in health care, RCNA believes that this would be more effectively done through an encompassing consultation rather than two fragmented consultations. ‘(RCNA)

- ‘Separating out the indicator work that is occurring in the general practice arena (by the RACGP and other organisations such as the Improvement Foundation) is not conducive to system reform, integration and consistency within primary health care, and indeed the health system as a whole. Ideally these pieces of work should be combined into one cohesive framework and we suggest that the Commission consider its leadership role in creating this framework…. all GPs were unclear about the RACGP’s work in the area of general practice indicators and quality improvement.’ (gpns)

Response: A broad range of health practitioners and representatives of peak and expert groups across primary health care have been involved in consultation to inform the development of the national set of practice-level indicators of safety and quality. (See Appendix 4 for details of consultation processes)

4.2.4 Potential duplication of indicator sets?

- ‘We note general practice is outside the scope of this project and this raises some concerns for us. In a patient-focused model of care, the consumer should be able to expect seamless care in a multidisciplinary team environment. In the paper, primary health care is defined as ‘… the entry point to the healthcare system for consumers.’ In our view, this highlights the criticality of alignment between these indicators and the indicators developed for general practice — an important step towards consumer-centred health care. This may be difficult to achieve depending on the timing and progress of this project and the project being managed by the Royal Australian College for General Practitioners (RACGP) to develop indicators for general practice.’ (NPS)

- ‘We note that the practice level indicators for general practitioners are being developed separately by the RACGP. We urge that these indicators be integrated into the final document and that they align with practice level indicators for other primary health care practitioners.’ (Primary Health Care Research and Information Service (PHCRIS)

- ‘AGPN notes that many of the currently suggested indicators are already present in the existing general practice standards for accreditation and/or as part of the Practice Incentive Payments (PIP) program for general practices which aims to enhance quality care in general practice. We would, however, like to emphasise the importance of developing and ratifying the final set of practice-level indicators in consideration of the vast array of other relevant available resources so that these indicators do not:

1) duplicate any existing work causing waste and inefficiencies;

2) cause confusion in relation to which indicators should (and in some cases must) be used in preference to other existing sets and;

3) contradict any measures or indicators currently in use or being developed such as those associated with general practice accreditation, the National Medicines Policy, Healthy Communities Reports etc.'
This will be especially important if the indicators move from voluntary to more mandatory uptake.’ (AGPN)

• ‘Primary care indicators are being developed by other national bodies such as the National Health Performance Agency. It is difficult to support this proposed set of 34 indicators in isolation. The feasibility of collecting and using what appears to be at least 3 national sets (including those being developed by the RACGP) is at the very least going to be problematic.’ (Medicare Local ACT)

• ‘The Australian Practice Nurses’ Association (APNA) recommends that the ACSQHC overtly commits itself to supporting a single suite of practice-level indicators of safety and quality for primary health care.’ (APNA)

• ‘The section on health reform was retrospective and our respondents felt the paper needed to more clearly articulate a potential vision (or a range of alternative visions) for an integrated approach to the use of indicators in the primary health care arena, inclusive of the roles the proposed health reform bodies and existing organisations might or could play.’ (gpns)


4.2.5 Too many indicators?

• ‘There are too many indicators. I believe there should be no more than 15 to concentrate on the most significant. The consultation paper has also not explored the issues that may arise between these indicators and accreditation processes. Some such as patient satisfaction appear in both. The accreditation standards prescribe a set number of patients yet these indicators suggest more than that may be required.’ (John Stafford)

• ‘It would be beneficial to minimise the number of indicators…. and to clarify what is intended through specification of a revised set.’ (Medicare Local ACT)

Response: Practice-level indicators of safety and quality for primary health care are intended for voluntary use in quality improvement strategies at the local practice or service level. The components of the local bundle of indicators should vary over time, depending on local circumstances, priorities for quality improvement, client needs, and the service’s scope of practice.

4.2.6 More specificity?

• ‘The RACGP believes that the suggested indicators may be difficult to implement or even interpret as most are too nonspecific.’ (RACGP)

• ‘The construction of many appears to be re-worded standards, rather than indicators...not clear how these [local] criteria will be developed...others within the appropriateness and acceptability dimension will require medical record audit to capture. The indicators under the effectiveness dimension are unlikely to measure what is intended.’ (Medicare Local ACT)

• ‘The text describing each indicator is too general. In this context, given that the document outlines that the indicators incorporate both process and outcome dimensions, it is suggested that the information in the description column needs to be more detailed for a number of the candidate indicators. It may also be worth clarifying
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whose responsibility it is to undertake certain tasks outlined in some of the indicators.’
(National Medicines Policy Committee (NMP))

• ‘The non-specific nature of some proposed clinical indicators may make them invalid to be used as comparators between practices. Many of the proposed clinical indicators are left to the local primary health care provider or practice to define. This may make assessments of comparison of performance between different practices invalid. The indicators are designed for all primary health care providers and are therefore, unlikely to be sensitive and specific to the needs of individual providers.' (The Royal Australian College of Physicians (RACP))

• ‘Many are too ambiguous and subjective which risk the indicators losing meaning and value as they are interpreted and applied differently over time and; stymies any opportunity to compare data/results across practices/organisations. AGPN recommends that all indicators are reviewed in this context, with actions taken to more clearly develop and define the benchmarks for which improvement is being measured against.’ (AGPN)

• ‘Most of the indicators do not meet the criteria set by the developers. They are not precise and cannot be implemented. ….. A targeted clinical audit may be a far more useful way of supporting practice improvement if appropriately robust indicators cannot be identified. There are some indicators with demonstrated validity that have not been included, for example, patients with asthma having an asthma plan. Most of the candidate indicators have been demonstrated to only have face validity and have not been linked to improved health outcomes. …The results sought could probably be obtained by a simple patient feedback mechanism asking about objectives met, satisfaction and any improvement in status. A selection of fewer indicators but with demonstrated validity is recommended.’ (RACP)

• ‘Practice-level indicators should be developed using clear, evidence-based rationales that are valid and appropriate for all health service providers.’ (APS)

• ‘It is crucial that denominators and numerators are well defined…. A consistent definition of ‘patients’ is presumed…. APNA is concerned by the definition of ‘regular’…. the term “multiple or chronic needs” [needs to be] defined reliably…..APNA recommends that the ACSQHC consider defining the ways in which numerators and denominators are calculated (rather than allowing practice-or-locality definition) in order to increase the reliability and comparability of data.’ (APNA)

• ‘In order to ensure consistency in interpretation and measurement, further definition of some indicators is required, for example: definition of timeliness, definition of specific measures of improvement in clinical outcomes.’ (NSW Health)

• ‘Clear explanatory text for each indicator is regarded as critical, inclusive of descriptions of the numerators and denominators.’ (gpns)

Response: A specification for the national set of practice-level indicators will be developed during the next phase of this project.

4.3 Suggestions

4.3.1 Definitions

• The following definition of primary health care is suggested by Statewide Service Strategy, SA Health.
“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”. [11]

- ‘Inclusion of the broader definition [11] will ensure that the quality and safety indicators are seen as applicable and relevant to the broadest range of primary healthcare providers; ensure that the indicators reflect the breadth of practice in the sector; drive quality and safety outcomes against best practice inclusive of prevention, early intervention and health promotion. ’(ISCHS)

- ‘The definition of primary healthcare given in the consultation paper does not adequately encompass the roles that primary healthcare services plan. Primary healthcare does include the ‘front line services’ listed in the document. However, in addition to this direct service provision, a definition of primary healthcare should include community development, health promotion, illness prevention, early intervention, outreach and chronic disease management, and a role in population health planning. In order to develop useful and valuable indicators on the safety and quality of primary healthcare services, it is important to identify not merely the services (types) which could be classed as primary healthcare services, but also the models of care of those services. The VHA defines primary healthcare as an approach derived from the social model of health that addresses the determinants of health.’ (VHA)

- ‘Primary health care is delivered by a vast and diverse range of health professionals, such as community health promotion officers, who would not generally be considered “clinicians” but who will play a role in quality and safety. Use of the term “clinician” throughout the document risks excluding these health professionals from adopting and using the indicators. “Practitioner” may be a more appropriate word given its broader definition.’ (AGPN)

- ‘Would be more comfortable with a list that relates to the traditional Primary Health Care services and just have an ‘alternate and traditional therapy’ category so that no one is excluded.’ (Statewide Service Strategy, SA Health)

- ‘The term ‘patient’ does not progress the values of health promotion and prevention that are intrinsic in primary health care…..RCNA highlights that the terms ‘consumer’ or ‘client’ would better align with the purpose of the project itself. …A broader definition that reflects an illness prevention and health promotion approach be utilised throughout the entire consultation.’ (RCNA)

- ‘The medical imaging service is considered not to be a primary health care service.’ (Australian Sonographers Association)

Response: Descriptions for some indicators should be reworded to reflect their broad applicability across settings and disciplines. Future documentation regarding the national set of practice-level indicators of safety and quality should provide a broader definition of primary health care.
4.3.2 Consumers’ role

- ‘The role of consumers ....should be expanded ie consumers should be actively involved in their own care, not just receivers of health information….more active partnership of consumers in their shared care would improve system safety.’ (Doug Stevenson, Southern Fleurieu Health Service, SA Health)

- ‘Consumers Health Forum (CHF) of Australia welcomes the Commission’s acknowledgment that safe and high quality care must be consumer centred and we urge the Commission to keep this as a guiding principle throughout the development and implementation of the proposed practice-level indicators…… Ongoing consumer engagement and involvement in the development of practice-level indicators and other quality measures is essential.’ (CHF)

Response: Indicators in the acceptability/patient participation dimension should be revised and/or added to reflect feedback on client engagement in their health care.

4.3.3 Chronic disease management

- ‘The provision of high quality integrated chronic disease management (ICDM) is of critical importance to the Australian health care system. We submit that the Commission should consider the Improving Chronic Illness Care tools (with appropriate modifications) as part of the final indicator framework for primary health care.’ (Australian Institute for Primary Care & Ageing) [Improving Chronic Illness Care: http://www.improvingchroniccare.org/]

Response: Noted
5 Gaps in the indicator set

5.1 Accessibility

- ‘Access….. is only captured in a very traditional / GP context….it does not measure anything to do with if there is access to services in a community and what level and type of service that is. And also measuring whether they choose not to access services for a whole range of reasons including cultural safety issues…How about … accessing (as above) returning to the service / following up / keeping appointments’ (CRANAplus)

- ‘SA recommends consideration in terms of provision of service in the ‘right place’ for the population needs – locality, mobile clinics, outreach, centre-based, home-based.’ (SA Health)

- ‘Accessibility to appropriate level of primary health care is important for the health of the Territorians, especially for the remote Indigenous residents….. Indicators here measure accessibility where a service is available….. so an indicator that provided a population level scan and measures of activity rate would be required. MBS or PBS expenditure could provide a useful population level indicator of accessibility.’ (Northern Territory Department of Health)

- ‘Additional accessibility indicators could reflect the need to assess the success of primary healthcare services at reaching the communities most in need, ensuring that an equity dimension is added to the measure of quality of care. This could be reflected in indicators to determine whether significant sub populations of the community with relatively lower health status had been identified and were accessing suitable services.’ (VHA)

- ‘RCNA believes that practice-level indicators in primary health care must also measure: if the catchment population is aware that the service exists; if the catchment population is aware of what the service provides; if there is outreach; if there is advocacy; if the services are accessible to children and young people and families / groups communities.’ (RCNA)

- [Include an indicator for] ‘First contact to service wait time for patients who are assessed as life threatening conditions and where emergency care has been implemented.’ (Heart Foundation)

- ‘Additional [accessibility] indicators could be developed in the future to reflect referral acknowledgement and response time.’ (VHA)

- ‘Accessibility should include a dimension related to time from onset of symptoms/problem to time seen by an appropriate clinician.’ (Dr Brian Maguire)

Response: A range of population level and specific indicators have been suggested. No change to indicator set.

5.2 Appropriateness

- ‘The appropriateness indicators would benefit from an additional indicator that examines the proportion of clients who were screened for a range of health, welfare and social issues on initial intake or needs identification. This indicator would be distinct from the medical focused health summary and would reflect the role of many
primary healthcare providers in comprehensively assessing and addressing the needs of clients.’ (VHA)

- ‘Practice-level indicators under Appropriateness should include an indicator on the evidence of screening for a broad range of physical, psychological and social health indicators. The patient assessment indicator [could] be changed or an additional indicator included to reflect assessment of physical, psychological and social health indicators within scope of practice. Alternatively needs identification could also be addressed through a single indicator covering both screening and assessment processes.’ (ISCHS)

- ‘The “Appropriateness” dimension notes the importance of having a comprehensive health summary. That dimension should include the importance of having a digital health summary that is accessible to all health care providers.’ (Dr Brian Maguire)

- ‘Whilst the indicators acknowledge cultural and linguistic diversity, they do not acknowledge literacy and numeracy more broadly, which are important communication issues.’ (NMP)

- ‘Consider an indicator relating to the practice’s clients’ health literacy levels.’ (gpns)

- ‘The indicators should be broadened to include annual client health records audits against the health privacy principles and privacy legislation.’ (ISCHS)

Response: The client assessment indicator should be revised to incorporate screening. Note that a project on health literacy has been initiated by the Commission for 2012.

5.3 Acceptability / patient participation

- ‘A measurement of community engagement and participation in design and planning of health services to meet community needs so that communities are empowered.’ (Statewide Service Strategy, SA Health)

- ‘SA recommends greater emphasis on patient and carers actual engagement in the decision-making and choices around care.’ (SA Health)

- ‘Include an indicator in the acceptability / patient participation on patient / consumer involvement in the development of their consumer led Care Plan’ (ISCHS)

- ‘Patient partnership: practice has involved patients in the discussion of strategies for continuous quality improvement based on the results of the patient experience instrument.’ (CFEP Surveys; West Moreton – Oxley Medicare Local and Brisbane South Division)

- ‘A component of patient participation is the geographical distance between patient and provider. For patients with large distances between them and their closest health care provider, there should be a dimension for alternative home care options.’ (Dr Brian Maguire)

- ‘A new indicator could be introduced around the number of patients who carry a personal medicines list.’ (NPS)

- ‘It is suggested candidate indicators to support the measurement of availability and accessibility of patient information and of strategies and support to enable patients to participate in decision making about their own care as well as to provide feedback about it should also be included.’ (Allied Health Professionals SA)
Synthesis of submissions on the consultation paper and recommended national indicator set

- ‘AGPN questions the effectiveness of using process only indicators in the acceptability/patient participation dimension and in particular whether this would encourage continuous quality improvement within primary health care organisations. Although AGPN agrees that process measures are important, we suggest that outcomes-focused indicators be considered for inclusion in this dimension. For example, indicating whether the practice has responded to the results of patient experience surveys by developing an action plan to achieve necessary improvements, rather than simply measuring whether a patient experience survey has been provided and filled out.’ (AGPN)

Response: Indicators in the acceptability/patient participation dimension should be revised and an indicator added to reflect feedback on client engagement in their health care.

5.4 Effectiveness

- ‘Effectiveness of health services should include a measure of consumer determined effectiveness which empowers individuals to self manage their own health and decide what outcomes are meaningful to them.’ (APS)

- ‘Regarding outcomes of healthcare, although this can be defined broadly, measures of this kind do not appear within the current indicator set, unless the outcomes of best practice are considered an ‘outcome’ of healthcare as opposed to outcomes for the patient. Outcomes are difficult to measure, however, we suggest greater consideration of new/future outcome measures be undertaken.’ (HQCC)

- ‘The section on effectiveness is limited reflecting the lack of existing measures in this area. There needs to be considerable future research to identify and measure the indicators of effectiveness in primary healthcare….Long term outcome indicators (e.g. quality of life indicators) are less directly attributable to the intervention of primary healthcare services.’ (VHA)

- [Include an indicator for] ‘the proportion of regular clients that have improved as measured through a validated self rated health status instrument.’ (VHA)

Response: An indicator should be added to the effectiveness dimension to reflect feedback on consumer determined effectiveness.

5.5 Coordination of care

- ‘The collaborative partnerships with other agencies needs to be further emphasised / elaborated, particularly in coordination and collaboration.’ (Doug Stevenson, Director, Southern Fleurieu Health Service, SA Health)

- ‘The coordination of care indicators in this section reflects key processes in coordination of client care. Feedback received from the sector indicated the need to address effective communication from referrers to primary healthcare as well as from primary healthcare.’ (VHA)

- ‘Practice-level indicators in primary health care must also measure if there is collaborative care across multi-sectoral areas versus referral and coordination.’ (RCNA)

- ‘There is no item about the location of and contents of living wills and other instructions.’ (J Stafford)
5.6 **Continuity of care**

- ‘The current weakness in our Australian Health system is the current failure of clinicians to close the cycle of care leaving people vulnerable to clinical error especially when moving between sectors or disciplines. Handover must be…expressed in practice level indicators for primary care.’ (Primary Care Network, Department of Health WA)

- ‘There is nothing specifically relating to a consistent and agreed practice approach to handover. Would it be useful to consider an indicator about addressing the practice’s approach to having in place a “formal system for or position on clinical handover, consistent with the ACSQHC guidelines, to all referring clinicians/the usual GP etc?’ (gpns)

- ‘For this domain, SA recommends consideration of additional indicator(s). For primary health care continuity of care means the care plan is implemented and reviewed to ensure it meets changing needs. It also means that with staff change there is adequate handover, and the patient and carer experience is of seamless care. Some of these elements are captured in other indicators.’ (SA Health)

- ‘The issue of access to patient records between providers and patient referral pathways is not addressed in the paper and this can be a major barrier to continuity of care.’ (Queensland Health)

**Response:** Refer to the National Safety and Quality Health Service Standard 6 - Clinical Handover.

5.7 **Safety**

- ‘Add Patient safety incident rate “The proportion of incidents that have occurred as compared to the actual services delivered.”’ (HQCC)

- ‘With the goal of “improving safety and quality in primary health care” it must be noted that “safety” must be inclusive of both patient and provider. Indicators should include both the number of adverse outcomes among patients and the number of illnesses and injuries among the workforce.’ (Dr Brian Maguire)

- ‘There are a number of medication safety indicators developed through the Australian Council on Healthcare Standards (EQUIP5) that are equally relevant to primary care and could be utilised for this purpose e.g. warfarin management, adverse drug reactions documented in the dispensing software, drug interventions, and the number of interprofessional collaborations undertaken to discuss clinical issues.’ (PSA)

- ‘The candidate indicators should be broadened to include in the dimension of safety, annual infection control audits of clinical services.’ (ISCHS)
Synthesis of submissions on the consultation paper and recommended national indicator set

• ‘The…..area not visible is in terms of safety, the level of experience, competence of
  the providers.’ (CRANAplus)

• ‘APNA recommends that the ACSQHC explore the inclusion of candidate indicators
  for staff safety.’ (APNA)

• ‘SA notes that drug reactions, allergies, infections and incident management have
  been assigned indicators. Incidents in primary health care cover other areas such as
  falls, skin tears and pressure injuries, recognition and response to deterioration,
  failure of equipment and device issues, so additional indicators may be required.’ (SA
  Health)

• ‘The safety dimension indicators need to be boosted to incorporate measures
  associated with a proactive approach to occupational health and safety across a
  much broader range of areas. As well as a specific ‘infection control’ indicator, the
  safety indicators should also cover sharps’ use and disposal, medication and vaccine
  storage, patient/clinical handover processes and general occupational health and
  safety matters relevant to practice set-up (eg steps/ramps, lighting, falls prevention
  etc). Of particular importance would be a measure associated with health
  professional safety in relation to difficult and/or potentially aggressive patients that
  covers both in practice as well as out of practice/home visit situations both in and out
  of normal hours. We would also see value in adding an indicator that relates to
  patient privacy and health information management.’ (AGPN)

Response: Refer to the National Safety and Quality Health Service Standards: Standard
  4 – Medication Safety; Standard 6-Clinical Handover; Standard 10 – Preventing Falls and
  Harm from Falls.

5.8 Determinants of health

• ‘Primary healthcare services play a wider community role as a result of their position
  at the ‘front line’ of access to health services. Indicators should reflect the extent to
  which this role is being fulfilled, such as screening for aspects of the social
  determinants of health, for example substance abuse.’ (VHA)

• ‘The Australian College of Rural and Remote Medicine is disappointed that
  subsequent indicators relevant to rural and remote practice have not been developed.
  Indicators important in the rural and remote context include things such as structure
  e.g. workforce, determinants of health or dimensions of health care performance e.g.
  outcomes = health status and community and health care characteristics.’ (Australian
  College of Rural and Remote Medicine)

• ‘Improving safety and quality in primary care should not be determined solely at the
  provider level but should incorporate a biopsychosocial view of health which
  assesses safety and quality as determined by medical, psychological and social
  determinants of health.’ (APS)

• ‘Any quality indicators must include measures of the more important lifestyle
  determinants of health…The indicators cannot remain narrowly fixated on measures
  of medical care.’ (John Stafford)

Response: Indicator 6 in the appropriateness dimension should be revised to include
  screening.
5.9 Prevention and promotion

- ‘There should be general indicators on prevention and health promotion, and early intervention.’ (ISCHS)

- ‘Add “Ongoing prevention management: The proportion of patients who are identified as being at high risk of developing a chronic disease and listed on an appropriate practice-level register system for ongoing prevention management”.’ (Heart Foundation)

- ‘Add “Ongoing prevention management: The proportion of patients who are referred to available multi-disciplinary lifestyle as appropriate”.’ (Heart Foundation)

- ‘The “candidate indicators” note dimensions that all occur after the illness or injury have occurred; there must be indicators related to preventing injuries and illnesses and indicators related to improving health. Examples could include: proportion of the community who smoke; seatbelt usage; proportion of children in car seats; teenage drunk driving incidents per year; domestic violence incidents; falls among the elderly resulting in hospitalization. Community health indicators could look at community level indicators of conditions such as diabetes or high blood pressure or obesity.’ (Dr Brian Maguire)

- ‘RCNA recommends that the practice-level indicators in primary health care include health promotion, health education, public health measures and epidemiology.’ (RCNA)

- ‘Concern was raised that measures for the health promotion and community development activities undertaken in primary health care would not be captured.’ (SA Health)

Response: No change to indicator set. The Commission has initiated a project on whole-of-system indicators of safety and quality.

5.10 Data quality

- ‘I’d propose the inclusion of an indicator that would deal with data completeness and accuracy eg for the example in Table 6, data completeness and accuracy would look at the percentage of patients with diabetes with no HbA1c recorded / no smoking status recorded / no blood pressure or feet examination recorded / no allergies recorded over the past 12 months OR percentage of diabetes patients removed from the clinical database (inactivated) due to relocation or death.’ (Alex McLaren, Wentwest Division of General Practice)

- ‘The APNA is disappointed that the paper omits a focus on the consistency and accuracy of coding / collection of ‘clean’ data….APNA recommends that the ACSQHC explore the inclusion of candidate indicators that focus on the constancy of coding, especially to nationally agreed standards’. (APNA)

Response: No change to indicator set.

5.11 Organisational characteristics

- ‘The indicators outlined in the consultation paper reflect a patient/service delivery-centric understanding of primary health care. This fails to capture the importance of staff training and education in the delivery of safe and high-quality primary healthcare,'
and an indicator could be developed to reflect this. Additional measures of appropriateness have been proposed in Victoria...[e.g.] the percentage of staff who are appropriately credentialed, had their scope of practice defined, received supervision and performance appraisal.’ (VHA)

- ‘Indicators should be developed around the other domains of clinical governance such as organizational and staff development and community participation in health and safety initiatives. It is recommended that indicators should include: annual staff credentialing reports; evidence of continued professional development; consumer involvement in recruitment and selection processes and service planning and development.’ (ISCHS)

- ‘Given the identification of the importance of Clinical Governance within the Consultation paper as a key to health care quality, AHPSA members felt it important to include indicators that would explicitly reflect this area. For example, candidate indicators for the Appropriateness dimension may include Provider Competencies and Credentialing against Scope of Practice, Provision of Evidence Based Practice and availability and Access to Professional Support and Supervision. While not specifically patient focused measures, there are clear and obvious linkages between each of them and the type and degree of patient outcomes.’ (Allied Health Professionals SA)

Response: No change to indicator set.
6 Comments regarding implementation

6.1 Data collection

- ‘Data collection required for many of these indicators will be challenging…[for example] the proportion of a patient population…processes and systems will need to be established.’ (Philippa Cahill, Service Manager Palliative Care, SESIAHS)

- ‘It took some significant effort for [practices] to remove patients who were not…active patients….poor recording of information and poor systems….Most practices will struggle to meet the data requirements…many practices, particularly the smaller ones, maintain primitive data collection systems.’ (J Stafford)

- ‘The RACGP is also concerned about the capacity of primary healthcare providers to easily capture data. Capturing data requires systems and some form of audit tool at the local level in order to manage and maintain indicators.’ (RACGP)

- ‘Only outpatient services in large hospitals, or very large ‘specialist’ clinics would have the resources to maintain the records and extract the information necessary to generate any of the proposed indicators.’ (Statewide Service Strategy, SA Health)

- ‘Data availability always poses a challenge and we have found there is often a need to encourage the collection of data aligned with quality outcomes that are not presently collected or are more difficult to obtain in the current setting…. the key areas of quality should be identified first, which would dictate the data to be collected and subsequently, the availability of such data would need to be considered.’ (Health Quality and Complaints Commission)

- ‘We encourage a realistic approach to collecting data for the most suitable indicators for each practitioner. It is to be acknowledged that data collection and audit in small practices requires proportionately significantly more effort than in larger practices. Some of the indicators may be harder to measure than others and [we] encourage more practical reflection on whether the effort required to measure a particular indicator is warranted. Much data is currently being collected that could be used for practice-level indicators and [we] suggest that this data should be made available rather than duplicate data be collected. Medicare data is one such source.’ (PHC RIS)

- ‘Selection of the final indicators should seek to utilise available data from existing data sources within primary care wherever possible rather than necessitating new data collections.’ (NSW Health)

- ‘The implementation of these indicators at a local level would have to include Justice Health specific guidelines to ensure the collection of data is appropriate, representative of our patient population and meaningful. Justice Health collects the majority of these indicators currently along with more detailed data on some indicators, such as those in the coordination of care dimension. These data are drawn from a variety of sources and there would be potential resource implications in ensuring reporting is able to occur on all indicators in a coordinated and consistent way.’ (Justice Health NSW)

- ‘It is likely that several of the proposed indicators would need to be collected manually (as opposed to electronically extracted from software systems) and this is considered to be a significant potential barrier to uptake and participation. This would also increase the risk of data collection being open to interpretation, and therefore not...’
enable like comparisons say, between providers within the same practice, or comparisons with different time frames.’ (gpns)

- ‘Our experience in monitoring hospital compliance with regulated standards in Queensland for more than four years has shown that differences in local implementation, documentation and auditing methodology are important considerations in apparent variation over time and between providers..... We have also found that acute care facilities in Queensland have improved their capacity to collect data, provide meaningful results and self-monitor. The capability to conduct audits and provide numerical data has improved over time with the number of hospitals involved in audits increasing on average by 50% per standards over four years.’ (Health Quality and Complaints Commission)

### 6.2 Integration with existing processes and initiatives

- ‘The VHA believes that indicators should be considered as a tool for improvement, not an isolated data collection exercise. It is therefore recommended that the Commission highlight the need for services to align indicators to specific organisational strategic and quality goals to ensure these indicators are integrated within existing organisational planning and evaluation frameworks and not seen as a stand-alone activity.... The VHA welcomes an implementation plan that assists local areas and practices to determine the set of indicators most valuable to the monitoring of their service.’ (VHA)

- ‘How would the use of the indicators fit with existing standards and accreditation and regulatory processes?..... Respondents felt that Medicare Locals and professional representative bodies might provide significant support for implementation, but that how those processes would be integrated and resourced was unclear. Using such indicators for quality improvement purposes will be very resource intensive, particularly for sole private practitioners. Perhaps the paper could reflect that having quality management systems and accreditation be suggested as the first step in the quality improvement process, and that use of indicators as part of that CQI system be described as the next step.’ (gpns)

- ‘The accessibility indicators are similar to the APCC access indicators but worded differently. Again, consistency would be ideal, potentially enabling comparisons between primary care practices in the future.’ (gpns)

- ‘Participation in quality improvement activities should be mandatory within the primary care environment. In this scenario, a menu of indicators would support the process of identifying areas that require attention and specific could therefore be voluntary...... We suggest articulating the need for indicators to be compatible with what will be contained and recordable within the PCEHR.’ (NPS)

- ‘There is some concern around the timing of the indicators given that primary health care is the core business of the Medicare Locals which are currently being established.’ (Queensland Health)

### 6.3 Use for comparison and benchmarking

- ‘Although the Commission has a statutory obligation to develop indicators there is no corresponding obligation for providers to adopt them...it does mean that the indicators usefulness in providing performance management and benchmarking information is limited from the system manager perspective..... There is a risk that the current approach for primary health care providers will impose an administrative burden without systematically collecting data to aid overall funding decisions or
service evaluation. The accountability for implementing the indicators or their findings is unclear.’ (Queensland Health)

- ‘The link between the Medicare Locals and the Local Health and Hospital Networks with each sharing and agreeing to monitor the same concepts will be important here. We suggest a coordinated approach between Medicare Locals so that comparison could be made. Greatest emphasis should be on the comparison within a service, however, some level of understanding across similar peers will be beneficial to health service providers. The more health services that use the indicator set, the greater the need for shared definitions and methodologies so that comparison and benchmarking can easily be undertaken at the local level.’ (HQCC)

- ‘The many and varied environments in primary care may make meaningful comparison between providers difficult. Consideration should be given to indicator structure to enable appropriate review across peer groups.’ (NSW Health)

6.4 Core set

- ‘We seek assurance that there will be some core compulsory practice-level indicators, including measurement of the patient experience.’ (CHF)

- ‘APNA recommends that the ACSQHC make participation in practice-based reporting against a minimum set of safety indicators mandatory.’ (APNA)

- ‘Potential problems in selecting indicators on their own eg patient experience, did not attend can’t be measured without some of the other measures providing context ….. If SA Health agree that the broad domains are relevant, it is proposed that implementation should include some ‘core’ indicators (e.g. one from each domain), then the service able to select others. There needs to be some guidelines or indicative benchmarks available.’ (Statewide Service Strategy, SA Health)

- ‘As a group we welcome the suggested candidate indicators 13 and 15 which pertain to use of interpreters and providing culturally sensitive and linguistically appropriate information. Certainly these indicators would enhance access to services and patient safety for those of culturally and linguistically diverse (CALD) backgrounds. We are concerned that these are voluntary indicators and that at the practice level the bundling of indicators may not include these two. We would therefore like to see a statement that indicates the importance of inclusion of these indicators to increase access for CALD consumers’. (NSW Multicultural Health Managers Forum)

6.5 Clinical governance

- ‘Many private primary care providers do not have any formal clinical governance frameworks in place …. The latest edition of the RACGP standards has new standards reflecting clinical governance and risk management. However, a large proportion of other primary private practices are not accredited; do not have standards against which they practice and do not have any formal clinical governance frameworks in place.’ (gpns)

6.6 Profession specific approaches

- ‘All quality systems that support Allied Health Professional practice either in the acute or primary health care sectors must allow for profession or discipline specific approaches as well as multidisciplinary opportunities….This needs to be overt in any safety and quality system developed for Allied Health Professionals.’ (SARRAH)
Synthesis of submissions on the consultation paper and recommended national indicator set

- ‘It is important that the description of indicators themselves as “measure of markers of the quality of care delivered by primary healthcare providers at the service unit, practice or local level” should not conflict with professional competencies and standards required by regulation authorities and professional bodies for health professionals, but complement them.’ (RCNA)

- ‘A manner in which the Commission could be more inclusive of all health care providers and develop meaningful biopsychosocial indicators would be to develop a companion document outlining the intent of the indicators and to encourage the development of industry/profession specific indicators using the Commission indicators as a framework.’ (Australian Psychological Society)

- ‘DAA supports the statement that “care provided by the clinical workforce is guided by current best practice, as agreed by the appropriate body”. It will be important that health care agencies recognise self-regulated professions with similar standards to the professions registered under the Australian Health Practitioner Regulation Agency as the “appropriate body”. These self regulated professions include dietetics, speech pathology, audiology, exercise and sports science, sonography and social work.’ (DAA)

6.7 Support for implementation

- ‘We believe it would be difficult for individual practitioners and small practices to undertake [identification and analysis of characteristics and social determinants of health of the local community] due to limited time and resources. We therefore suggest that external or larger organisations should be engaged/encouraged to support smaller sites to increase their capacity to undertake appropriate sampling, follow-up and analysis in a timely manner.’ (Health Quality and Complaints Commission (HQCC))

- ‘It is essential that this project integrates with training in the health professions…. If the health workforce is trained in a disease-based model, the vision proposed by the Commission is likely to fail. The proposed framework needs to be integrated into Government policy at all levels and developed to drive policy and funding of all services.’ (ACPA)

- ‘If the Commission expects the national implementation of the practice-level indicators consideration must be given to support both private and public sector development.’ (SARRAH)

- ‘For true reform to happen these indicators must have some financial benefits. I strongly support the withholding of a proportion of MBS revenue…. Some consideration must be given to paying practices for these additional costs.’ (J Stafford)

- ‘Consideration should be given to allocation of funds to support the development and implementation.’ (Philippa Cahill, Service Manager Palliative Care, SESIAHS)

- ‘It is also important that the paper provide some sense of how implementation at the practice and system level might occur and in particular, be resourced.’ (gpns)

- ‘The Heart Foundation recommends that services are strongly encouraged to implement practice-level indicators, and that appropriate incentive strategies (i.e. financial support, opportunities for support and collaboration) are also developed to foster the uptake of candidate indicators.’ (Heart Foundation)
Synthesis of submissions on the consultation paper and recommended national indicator set

- ‘There is solid evidence that a comprehensive quality improvement process that combines clinical audits with broader organisational system systems can help improve the quality of care in primary health care settings in Australia. A systems-oriented approach and mechanisms that facilitate discussion about quality across primary health care centres support engagement with, update and impact of quality improvement processes. Indicators are only as good as the frameworks or systems that support their implementation. Supportive infrastructure (such as data systems) and workforce development training are important facilitators of wide spread update of continuous quality improvement processes.’ (Menzies School of Health Research)

- ‘Maintaining an adequate health workforce is a significant challenge to service delivery in the Northern Territory and adds to the challenge of benchmarking health care services and meeting national quality standards. Practice-level indicators are extremely useful when used by clinicians for service improvement. Alone, though, they can be difficult to interpret……the best use of indicators of this type is when they are discussed and digested by health staff who have access to local, regional and national context for their results.’ (Northern Territory Department of Health)

- ‘There must be clearly defined methods for implementation of practice-level indicators across primary health care services.’ (CHF)

- ‘APNA recommends that the ACSQHC remove all reference to documentation of adverse events until robust arrangements for qualified privilege are widely adopted in primary care. In the interim, APNA recommends that candidate indicators that focus on near misses be explored. APNA recommends that the ACSQHC explore enhancements of jurisdictional legislation providing qualified privilege such that it is clear that feasible models in primary care (e.g. clinical meetings) would be covered by qualified privilege.’ (APNA)

6.8 Piloting the indicator set

- ‘Once the indicator specifications have been designed, the RACGP suggests that the indicators are rigorously tested with piloting in a range of primary care settings to ensure validity and reliability.’ (RACGP)

6.9 Guidance on sample size

- ‘The key issue facing the effective implementation of any indicator set in primary healthcare services is the ease of data extraction. In Victoria, to date, the ability to extract data related to the proposed indicator set would rely largely on manual audits of files. In recognition of this it may be useful to include advice on sampling size and methodology to assist services in obtaining useful data from a sample of files that can inform quality improvement. In the longer term funding bodies need to consider building in data extraction for quality improvement in any software systems requirements.’ (VHA)

- ‘Guidance [should] be given on aspects of data collection and audit. For example, when sampling from the population, minimum sample size requirements should be encouraged.’ (HQCC)
7 Specific comments on candidate indicators

The candidate indicators listed in Table 5 below were identified during the scan of Australian and international quality and safety indicator sets, and during the consultation processes. [5, 6, 13, 14, 15, 16, 17, 18] The candidate indicators have been suggested for inclusion in the national set of practice-level indicators of safety and quality for primary health care.

The framework for the candidate indicator set has been adapted from ISO FDIS 21667 Health Indicators Conceptual Framework [1], and also incorporates some process and outcome dimensions of primary health care as defined by Kringos et al [2] (see Appendix 2).

Responses to the consultation paper have informed the recommended national set of practice-level indicators of safety and quality. Comments and/or suggested changes received in submissions to the consultation paper are in italics. The Consultation Paper, and submissions, are available from http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/PriorityProgram-08_PracticeLevelIndicators

The candidate indicators are categorised in the following dimensions:

- accessibility
- appropriateness
- acceptability/patient participation
- effectiveness
- coordination of care
- continuity of care
- safety.

Table 5: Candidate practice-level indicators of safety and quality for primary health care

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<thead>
<tr>
<th>Dimension</th>
<th>Candidate indicators</th>
<th>Description</th>
<th>Recommendation</th>
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<tbody>
<tr>
<td>Accessibility</td>
<td>First contact to service wait time</td>
<td>The proportion of patients whose wait from first contact to first service is within the locally agreed timeframe. Indicator should be patient centric rather than locally based. There should be a fixed recommended waiting time based on the clinical need (J Stafford) Not supported. Reliable data unlikely. Does not measure or reflect service mal-distribution or inaccessibility (NT DoH) Applicable – high (Dr Murray Thomas) Accessibility indicators will have limited usefulness in primary health care for services such as pharmacy practice. (PSA) “First contact’ is vague and needs to be more specific. It could mean first phone call or first interface. Most practices don’t usually contact informal first contact. (RACP)</td>
<td>Retain</td>
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<td></td>
<td></td>
<td></td>
<td>Replace ‘patients’ with ‘clients’</td>
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<td></td>
<td></td>
<td></td>
<td>Define ‘first contact as initial needs identification / initial intake’</td>
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<td></td>
<td></td>
<td></td>
<td>Clarify ‘locally agreed’</td>
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Note: ‘The definition of a regular client can vary depending on the context and/or collection in which the term is being applied, but generally involves a minimum number of visits to an organisation or agency or uses of a facility, occurring over a specific period of time. For example, in the primary health care context, a regular client may be someone who has visited a particular primary health care provider three or more times in the past two years’. Reference: Person – regular client indicator, yes / no code N METeOR identifier 436639 (Accessed 9 September 2011, at http://meteor.aihw.gov.au/content/index.phtml/itemId/181162)
### Dimension Candidate Indicators

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Candidate indicators</th>
<th>Description</th>
<th>Recommendation</th>
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<tbody>
<tr>
<td><strong>Clarification of the definition of first contact needs to be made. (VHA)</strong></td>
<td></td>
<td>General agreement, with the proviso that first contact’, ‘first service’ and ‘locally agreed timeframe’ are given further definition. (SA Health) ‘First contact’ not clearly defined (gpns)</td>
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<tr>
<td><strong>First contact to service wait time for high-priority patients</strong></td>
<td></td>
<td>The proportion of patients who are high priority according to locally agreed criteria, and whose wait from first contact to first service is within the locally agreed timeframe May be possible, subject to same limitations as 1 (NT DoH) Applicable – high (Dr Murray Thomas) Indicator should be patient centric rather than locally based. There should be a fixed recommended waiting time based on the clinical need (J Stafford) Clarification of the definition of first contact needs to be made. (VHA) In Victorian community health the key points of contact are first contact of the client with the agency, initial needs identification of the client and first service with service provider. For many Victorian agencies indicator 2 will be better designed as time from initial needs identification to first service (VHA). Agreement, with the proviso that there is further definition to enable a common approach. (SA Health) ‘First contact’ not clearly defined (gpns)</td>
<td>Retain</td>
<td>2</td>
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<tr>
<td><strong>Eligible patients who received a service</strong></td>
<td></td>
<td>The proportion of eligible patients requesting a service who received a service Looks to be fairly vague in description and subjective...required to report on every activity? How does indicator differ from 6, 8, and 10? (J Stafford) May be possible, depending on how defined (NT DoH) This indicator has high relevance to government and non-government agencies providing prescribed services to an eligible patient population and dental practices that have established a ‘preferred provider’ arrangement with a health fund. The vast majority of private practices encounters are based on a private contract between the patient and the dental practitioner including those patients eligible under government funding arrangements and associated schemes. Applicable – low (Dr Murray Thomas) The meaning of the description “The proportion of eligible patients requesting a service who received a service” is unclear because the sentence is poorly expressed. The sentence needs rewording so the meaning is clear. (RACP) Suggestion that this requires a timeframe, and also that unmet need is difficult to measure. (SA Health)</td>
<td>Retain</td>
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<tr>
<td><strong>Non-attendance at booked service</strong></td>
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<td>The proportion of patients who did not attend a booked service More likely to be a measure of patient compliance than the quality of a service (P Cahill) Non-attendance likely to be correlated to the waiting times...this indicator could be dropped (J Stafford) Not relevant to services which do not use bookings, is a system measure of efficiency, rather than an accessibility measure (NT DoH) Dental practices often use appointment history such as failed to attend with or without notification and cancellation without or without 24 hours notice as indicators and management tools. Applicable – high (Dr Murray Thomas) How easily is this measured? What information does it provide? How useful is the information (PSA) This is an outcome that is difficult to measure because of the reasons for non-attendance. For example, some patients may not attend because they did not have the money to pay for any gap fees they would have incurred. (RACP)</td>
<td>Retain</td>
<td>4</td>
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### Synthesis of submissions on the consultation paper and recommended national indicator set

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<tr>
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<tbody>
<tr>
<td>Appropriateness</td>
<td>Health summary</td>
<td>The proportion of regular patients with a comprehensive health summary, including information on allergies, current/past medical history, medications and risk factors, which was updated within the previous 12 months. All patients should have a comprehensive medical history, allergies, medications and risk factors...use of term “regular patients” seems to be a let out. (J Stafford) Supported (NT DoH)</td>
<td>Retain</td>
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</table>
| | | Dental practitioners usually do not use a health summary as such but rather a medical and dental history for each patient. As part of that history the following is collected:  
- relevant medical conditions  
- medication history including current medicines noting the drug name, dose, frequency and route of administration  
- relevant lifestyle and social factors  
- any adverse medicine event or allergies. Applicable – high (Dr Murray Thomas)  
The description refers to ‘regular patients’. A definition of ‘regular patients’ is required. The description also refers to ‘comprehensive health summary’. It should also state correct health summary as this is more important than a comprehensive health summary. (RACP) Medications are updated regularly and the annual timeframe for updating will be insufficient to capture current medicines information. (NPS) It seems problematic for many services to have complete control over the creation of, and updating of, ‘comprehensive’ health summaries. APNA recommends that the ACSQHC review the wording of indicator 5, with a view to making the indicator specific to the scope of care provided at the site (APNA)  
The list of examples might be expanded, if not in this table then in an accompanying document to include nutritional history, psychosocial history etc. (DAA)  
Add “which was updated on an equivalent to an appropriate practice-level register system with the previous 12 months” (Heart Foundation) Agreement with the suggestion that social and carer/family information should be included….risk factors may need to be described better (SA Health)  
This data can be collected in general practice particularly where there are electronic medical records. The resource requirements would need a Medicare Local to go into a practice and review patient files. This raises issues of patient privacy and the willingness of practices to allow outside agencies to do this. This data collection might be part of a pre-accreditation visit but is still resource-intensive. The benefit for a practice would need to be found to gain cooperation. (Melbourne East GP Network) | Clarify ‘comprehensive health summary’ Replace ‘patients’ with ‘clients’ | |
<p>| Patient assessment | | The proportion of patients assessed, using a validated assessment tool appropriate to the scope of the practice and patient’s needs. I strongly disagree with having assessments “appropriate to the scope of the practice”...assessment tools should be applied to all types of organisation equally. (J Stafford) | Retain | 6 |
| | |  | Revise description to “The proportion of clients” | |</p>
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<td><strong>Examples would help in the interpretation. Too general in its current form. Would need to be specific to be useful (NTDoH)</strong></td>
<td>assessed, using validated assessment and screening tools appropriate to the scope of practice and the client’s needs <strong>(Clarity ‘assessment’ and ‘valid assessment tool’)</strong></td>
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<td><strong>Assessment tools for use in dental practice are not well developed or in wide use. The oral examination, diagnosis and subsequent treatment or care plan informs the assessment of an individual patient. Applicable – low (Dr Murray Thomas)</strong></td>
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<td><strong>The validated assessment tool requires additional specification / explanation (PSA)</strong></td>
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<td><strong>DAA agrees with this candidate indicator but suggests that the concept be extended to include screening as a step before assessment. For example, screening for malnutrition in older Australians would be appropriate, but assessment would be undertaken if screening identified a certain risk for malnutrition. Screening tools being used should be validated and relevant to the population service by the primary health care agency. (DAA)</strong></td>
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<td><strong>Agreement with suggestions to include assessment of carer needs and ability to provide support, include both screening and assessment tools. (SA Health)</strong></td>
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<td><strong>Clarify ‘assessment’ and ‘valid assessment tool’</strong></td>
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<td><strong>Timely initial needs identification</strong></td>
<td><strong>Retain</strong></td>
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<td><strong>The proportion of patients whose initial needs identification was conducted, within the locally agreed timeframe</strong></td>
<td><strong>Replace ‘patients’ with ‘clients’</strong></td>
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<td><strong>What does this mean? If patients are assessed and put on care plans (which presumably have timeliness components) how does this indicator add to quality measurement (J Stafford)</strong></td>
<td><strong>Clarify ‘needs identification’</strong></td>
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<td><strong>The timeliness would need to be informed by best practice as well as local agreement (NT DoH)</strong></td>
<td><strong>Clarify ‘locally agreed timeframe’</strong></td>
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<td><strong>This indicator has high application in large multi-clinic practices. A patient’s initial needs will usually be identified on first contact with a private dental practice and, if appropriate, an appointment will be made or the patient directed to another facility. Applicable – low (Dr Murray Thomas)</strong></td>
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<td><strong>Agreement with ‘locally agreed timeframe’ are given better definition. (SA Health)</strong></td>
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<td><strong>Unclear – term ‘needs identification’ requires definition (gpa)</strong></td>
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<td><strong>Complete care plan</strong></td>
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<td></td>
<td><strong>The proportion of patients with multiple or complex needs who have a complete care plan</strong></td>
<td><strong>Replace ‘patients’ with ‘clients’</strong></td>
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<td><strong>Every patient of a primary health service that employs a general practitioner (health district community services operate in a different manner and this may not be relevant to them) should have a care plan….should be patient-centred rather than once a year…for healthy young patients a five-year plan seems more relevant (John Stafford)</strong></td>
<td><strong>Clarify ‘care plan’ including participation of clients in care planning</strong></td>
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<td><strong>Unsure what is meant by a complete care plan, and the relationship to a Medicare GP Management Plan. Ideally Care Plan refer to the scheduled items of future care delivery (NT DoH)</strong></td>
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<td><strong>The active participation of clients in the care planning process is not currently reflected. (VHA)</strong></td>
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<td><strong>A dental practitioner does not ‘medically manage’ a patient but may operate within a virtual interdisciplinary team as part of a patient’s ‘health neighbourhood’ eg Chronic Disease Dental Scheme. The dental equivalent is a treatment plan. Not applicable. (Dr Murray Thomas)</strong></td>
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<td><strong>The complete care plan reference should articulate a medicines management plan and test schedules/plans where appropriate. (NPS) [The care plan should be] aligned to clinical guidelines. (Heart Foundation)</strong></td>
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<td><strong>Agreement, with comments that development of a care plan is informed by the screening and assessment findings, and is a collaboration between all in the health care profession team, the consumer and the carer/family. Development of</strong></td>
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<td>Recalls and reminders</td>
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<td>The proportion of patients with a complete care plan who were given recalls or reminders as recommended in the care plan. General practices run adequate recall and reminder systems for the patients that they get on to systems. Should be a requirement for practices to an audit of these systems at least annually (J Stafford)</td>
<td>Retain</td>
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<td>Adherence to clinical guidelines</td>
<td></td>
<td>The proportion of patients with complete care plans that are in accordance with agreed clinical guidelines. The clinical guidelines must be national and predetermined. Only key conditions should be monitored (J Stafford)</td>
<td>Retain</td>
<td>10</td>
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<tr>
<td>Timely review of care plan</td>
<td></td>
<td>The proportion of patients with a recorded care plan that is reviewed by the planned review date. A dental practitioner does not ‘medically manage’ a patient. Not applicable. (J Stafford)</td>
<td>Retain</td>
<td>11</td>
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<tr>
<td>Medication review</td>
<td></td>
<td>The proportion of regular patients whose medication list was reviewed by a clinician within the previous 12 months. I support the availability of a patient’s medication history but believe that measurement and implementation may be too difficult as many patients in urban settings have several GPs. The person reviewing medications should not be the GP.</td>
<td>Retain</td>
<td>12</td>
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### Synthesis of submissions on the consultation paper and recommended national indicator set

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<td>co-ordinating the care for that patient ... ideally a pharmacist should also be involved (J Stafford Supported (NT DoH)) Yearly medication review is unnecessary for those without chronic illness (ie patients not taking any medications) (RACGP) A dental practitioner does not ‘medically manage’ a patient and a Medication Review is usually conducted by a doctor or pharmacist. Not applicable. (Dr Murray Thomas) What is the definition of clinician? Is it a health professional or a doctor? (PSA) We suggest rewording this to “the proportion of regular patients whose medicines have been reviewed by a clinician in accordance with locally agreed guidelines”. (NPS) Agreed, suggestion that this indicator may be better worded as “the proportion of patients attending in the last year / month whose medication list was updated if &gt; 12 months old”. Many primary health care services are not appropriate services to be undertaking a formal review of medication – will update list, note and refer concerns and queries to GP. (SA Health)</td>
<td>whose medicines have been reviewed by a health practitioner in accordance with locally agreed guidelines’.</td>
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<tr>
<td>Interpreter services</td>
<td>The proportion of patients who indicated their need for an interpreter and who were provided with interpreter services at the first service Include not only patients who indicate their need but also assessed as requiring an interpreter in the denominator (NT DoH) Indicator will be objective assessments of the appropriateness of services (J Stafford) Experience indicates that ethnic and cultural groupings readily identify a practice that aligns with their specific needs. Given the successful migration of large number of people to Australia over several generations it is most unusually to encounter a non-English speaking patient who has not been accompanied by a relative or friend who is able to assist through translation at the consultation. Applicable - low. (Dr Murray Thomas) Agreed (SA Health) Often the argument of lack of resources is raised when considering interpreters… there is a free doctor’s priority line for telephone interpreting. A similar free arrangement has been developed for pharmacies though the take up of this service is not clear as yet. Furthermore, public health services do have access to interpreters, though it is a scarce resource some days. (NSW Multicultural Health Managers Forum) This needs to more clearly reflect patients who require different types of communication assistance, e.g. deaf, mentally impaired etc. At the moment it implies assistance only with foreign language. (AGPN)</td>
<td>Retain</td>
<td>13</td>
<td></td>
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<tr>
<td>Aboriginal and Torres Strait Islander awareness/sensitivity</td>
<td>The proportion of Aboriginal and Torres Strait Islander patients who have received communications that are culturally appropriate SARRAH does not believe that the statement about Aboriginal and Torres Strait Islander health is strong enough nor does it support the equal partnership. (SARRAH) Indicator will be objective assessments of the appropriateness of services (J Stafford) It is not just communication that make a health service culturally safe and thus accessible to ATSI people (CRANAplus) NT DoH is currently evaluating the implementation of the Departmental Cultural Security Policy. Valid and useful measures of Aboriginal and Torres Strait Islander cultural security will emerge from that evaluation. In its current form the indicator is not able to be measured (NT DoH) This has high relevance for government and NFP agencies</td>
<td>Revise, pending outcomes from NT DoH project on cultural security</td>
<td>14</td>
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</table>
### Cultural and linguistic diversity awareness/sensitivity

The proportion of patients who have received communications that are culturally and linguistically appropriate

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<td>It is not just about communication (CRANAplus)</td>
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<td>An objective indicator is required (eg % of staff who have completed CALD training) NT DoH</td>
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<td>Experience indicates that ethnic and cultural groupings readily identify a practice that aligns with their specific needs. These practices invariably respond to the needs of specific ethnic groups that form part of the practice's patient base. Applicable - low (Dr Murray Thomas)</td>
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<td>How will this be measured? (PSA)</td>
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<td>Agreed in principle, however, a definition or measure of ‘appropriate communication’ may be difficult. Suggestion for a measure of staff training in cultural awareness…a culturally appropriate service takes into account the time and place of service delivery, and the health beliefs and health literacy of the group. (SA Health)</td>
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<td>What is ‘culturally appropriate’? This needs to be defined through the use of standardised guidelines/framework. (AGPN)</td>
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<td>Suggest this indicator becomes a more general indicator about clear and culturally/linguistically appropriate communication that can then be referred to in indicator 21. (AGPN)</td>
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#### Acceptability/ patient participation

Self-rated health

The proportion of regular patients who have completed a validated self-rated health status instrument that informs care and service improvement

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<td>Some value if a uniform tool like SF 36 were used…could be dropped (J Stafford)</td>
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<td>Supported (NT DoH)</td>
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<td>Seems unnecessary for the majority of patients (RACGP) Agreement in principle, with the proviso that the patient’s advocate can assist the patient to complete if they are unable to do so themselves. Some concern that self-rated health status on its own is insufficient to inform improvement to care and services. (SA Health)</td>
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<td>A dental practitioner does not ‘medically manage’ a patient. A pronounced asymmetric knowledge base of an individual’s oral health between patient and practitioner remains with the dental practitioner. This indicator is unlikely to provide additional insights provided by patient experience surveys. Not applicable (Dr Murray Thomas) APNA recommends that the ACSQHC review the wording of indicator 16, and replace the patient completion concept with the concept of offering the instrument. APNA is also concerned that this indicator will result in patients with complex needs being asked to complete a self-rated health</td>
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<td>and remote and regional dental practices. Disadvantaged Aboriginal and Torres Strait Islander patients are unlikely to access private practice dental services in metropolitan and regional centres. Applicable - low (Dr Murray Thomas)</td>
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<td>How will this be measured? (PSA)</td>
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<td>We note that identification of Aboriginal and Torres Strait Islander clients cannot be assumed in health service data; taken out of context, this indicator could provide a disincentive to appropriate identification of Aboriginality (Menzies School of Health Research)</td>
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<td>Agreed in principle, however, a definition or measure of ‘appropriate communication’ may be difficult. Suggestion for a measure of staff training in cultural awareness…a culturally appropriate service takes into account the time and place of service delivery, and the health beliefs and health literacy of the group. (SA Health)</td>
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<td>The proportion of patients who have received communications that are culturally and linguistically appropriate Indicator will be objective assessments of the appropriateness of services (J Stafford)</td>
<td></td>
<td>Revise title of indicator to ‘Cultural competency training’</td>
<td>15</td>
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<tr>
<td>It is not just about communication (CRANAplus) An objective indicator is required (eg % of staff who have completed CALD training) NT DoH</td>
<td></td>
<td>Revise description to ‘the proportion of the service’s eligible workforce who have received cultural competency training’</td>
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<td>Experience indicates that ethnic and cultural groupings readily identify a practice that aligns with their specific needs. These practices invariably respond to the needs of specific ethnic groups that form part of the practice’s patient base. Applicable - low (Dr Murray Thomas)</td>
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<td>Suggest this indicator becomes a more general indicator about clear and culturally/linguistically appropriate communication that can then be referred to in indicator 21. (AGPN)</td>
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<td>status by each site or program. (APNA)</td>
<td>Change wording to ‘that informs their individual care’ (AGPN)</td>
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<td>The proportion of regular patients who have been given the patient experience survey within the previous 12 months (using a standard patient experience instrument)</td>
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<td>Has undertaken a standard (validated) patient experience survey where the results have been collated and analysed independently, and which highlight areas of strengths and potential areas for improvement (CFEP Surveys; West Moreton – Oxley Medicare Local and Brisbane South Division)</td>
<td>Revise</td>
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<td>Systems we currently have for accreditation are of little value. The numbers are too small and practices are not inclined to change anything even when there are clear signs of a lack of quality (J Stafford)</td>
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<td>Supported, providing the methodology is appropriate to the practice and their clients groups (NT DoH)</td>
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<td>Agreement in principle, with the proviso that the patient’s advocate can assist the patient to complete if they are unable to do so themselves. Recommendation that carers are given similar opportunity to provide feedback. Surveys should include the patient and carers involvement with the development of the care plans. (SA Health)</td>
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<td>Identifying a ‘regular’ attender of a dental practice is subject to a broad range of important variables. The National Institute for Clinical Excellence has nominated recall periods of 3 – 24 months for a recall dental examination. Dependent on the field of dentistry, a dental practitioner may determine a recall examination period for a patient with consideration of the strong drivers of the effects of oral hygiene, diet, fluoride exposure, tobacco and alcohol use, medical conditions and the effects of medications. A consumer may regard themselves as a ‘regular attender’ if they visit once every 5 years or accompany their children to the practice. The strongest barriers to a consumer regularly attending is a favourable attendance profile, includes a patient’s physical and emotional factors, access issues, cost and the outcome of the consumer’s perceived ‘want versus need’ equation. Each practice or dental practitioner will need to define a ‘regular attender’. Applicable – high (Dr Murray Thomas)</td>
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<td>Does this survey incorporate a complaints reporting mechanism? (PSA)</td>
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<td>The usefulness of 17, 18 and 19 for quality improvement would be enhanced by including such measures as part of a quality improvement cycle, with linkages to specific aspects of systems strengthening. Consideration needs to be given to the cultural appropriateness and relevance of such tools to Aboriginal and Torres Strait Islander populations. (Menzies School of Health Research)</td>
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<td>In relation to the indicators under the Acceptability/patient participation dimension, it is suggested that the validation and quality improvement process is reflected so that it is not just a tick box exercise. (NMP)</td>
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<td>Add wording ‘to inform more general improvements in the type of care provided by the practice’ AGPN has recently piloted a patient experience survey instrument through the General Practice Network. Reports on these pilots are currently being collated. It is important – as argued in regard to other indicators – that standardisation in measurement of indicators is achieved where possible</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Dimension Candidate indicators Description Recommend-ation #

### Patient experience survey response rate

**Patient experience response (CFEP Surveys; West Moreton – Oxley ML and Brisbane South Division)**

The proportion of regular patients who have provided feedback about their patient experience within the previous 12 months (using a standard patient experience instrument) Agreement in principle, with the proviso that the patient’s advocate can assist the patient to complete if they are unable to do so themselves. Recommendation that carers are included. (SA Health)

Has responded to the results of patient experience results by drawing up a plan of intended actions (or “action plan”) (CFEP Surveys; West Moreton – Oxley Medicare Local and Brisbane South Division)

Supported, providing the methodology is appropriate to the practice and their clients groups (NT DoH)

Provision of feedback on patient experience is essentially a task for patients - remove indicator (APNA)

There is a strong likelihood that for the majority of small practices meaning data will be only be available through collection from the wider community eg a professional association channel or agency. Applicable – low (Dr Murray Thomas)

Proportion of patients comments responded to as a result of other forms of patient experience (eg web-based platforms) (CFEP Surveys; West Moreton – Oxley Medicare Local and Brisbane South Division)

Systems we currently have for accreditation are of little value. The numbers are too small and practices are not inclined to change anything even when there are clear signs of a lack of quality (J Stafford)

This data would be required on a 12 month basis. If practices undergo accreditation this is on a 3 yearly cycle. The Medicare Local would need an excellent relationship with a practice to obtain this data. (Melbourne East GP Network)

*Retain*

*Revise description to ‘The proportion of regular clients who have responded to a patient experience survey within the previous 12 months (using a standard patient experience instrument, that informs the service’s quality improvement)’*

### Satisfaction with patient experience

The proportion of regular patients who are very satisfied with specified elements of their patient experience within the previous 12 months (using a standard patient experience instrument)

Surveys should include the patient and carers engagement with the care, for example, involvement with the development of the care plan – rather than as passive recipients of care. (SA Health)

The proportion of regular patients who rate the service as ‘excellent’ with specified elements of their patient experience (using a standard patient experience instrument) (CFEP Surveys; West Moreton – Oxley Medicare Local and Brisbane South Division)

Supported (NT DoH)

The costs of collection of reasonable data set needs to be considered for practices operating as micro-businesses. Applicable – high (Dr Murray Thomas)

We suggest the following additional question to gauge satisfaction:

- satisfaction with the complaint process
- satisfaction with the complaint outcome (HQCC)

Systems we currently have for accreditation are of little value. The numbers are too small and practices are not inclined to change anything even when there are clear signs of a lack of quality (J Stafford)

If a practice conducts a patient survey (as per accreditation 3 yearly) a Medicare Local could collect this data as long as the practice agrees to provide the report. The ML would need an excellent relationship with a practice to obtain this data. (Melbourne East GP Network)

*Retain*

*Replace ‘patients’ with ‘clients’*
### Dimension Candidate indicators

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Candidate indicators</th>
<th>Description</th>
<th>Recommendation</th>
<th>#</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient complaints response</td>
<td>The proportion of patient complaints responded to within the service’s nominated timeframe from receipt of complaint. Agreed. Recommend including advocates and carer / family complaints. (SA Health)</td>
<td>While the response rate may be an indicator it is likely to correlate highly with the overall satisfaction rating and could be dropped (J Stafford) Supported (NT DoH) Consumer complaints about dental care usually relate to either the direct clinical care by a dental practitioner or the related services and administration. They broadly can be classified as an enquiry, insurer notification and a complaint or claim. <strong>Enquiry:</strong> those low level matters where an explanation or clarification of circumstances satisfies or resolves the consumer’s concerns. No further risk or future action against the dental practitioner or practice is indicated. <strong>Insurer notification:</strong> is a complication or incident that has not caused the patient to make any complaint or claim, but has the potential to become a complaint or claim in the future. The dental practitioner would usually seek assistance in management of the incident and report the matter to the Professional Indemnity insurer is required. <strong>Complaint or claim:</strong> these matters in which a patient, or person on behalf of the patient, has made a verbal or written complaint to the practitioner or to a statutory or legal body, regarding some element of care that has been provided by the dental practitioner or practice to the patient. A practice exercises discretion in determining acceptable timeframes for handling enquiries but insurer notifications, complaints or claims are often subject to time constraints imposed by the insurer or statutory body such as health compliant entity, AHPRA, dental board, NSW Dental Council, small claims tribunal, Medicare Australia or civil or criminal court proceeding. Applicable – high (Dr Murray Thomas) How are complaints received? (PSA) Some complaints may be verbal and informal and are normal. Accordingly, the definition of the type of complaints that need to be responded to needs to be more specific. (RCPA) General Practice Accreditation requires that practices have a system for patient complaints. This could be audited by a ML for data collection for these indicators. (Melbourne East GP Network)</td>
<td>Retain</td>
<td>20</td>
</tr>
<tr>
<td>Patient partnership in quality improvement</td>
<td>The proportion of clients who have been invited to contribute to quality improvement activities based on the results of the patient experience survey</td>
<td>New indicator</td>
<td>A</td>
<td></td>
</tr>
<tr>
<td>Informed consent for treatment</td>
<td>The proportion of patients (and/or carers) who have had information about the purpose, treatment options, benefits, risks and costs of care discussed with them I wonder how it will be measured…could be dropped (J Stafford) Not supported. Not possible to collect (NT DoH) A dental practitioner relies on implied consent to undertake preform a dental examination of a patient. The examination is undertaken on the basis of the patient having made the appointment, attending and allowing the physical examination to occur. Any subsequent treatment requires the patient to make an informed decision and consent to the treatment either verbally or in writing dependant on the procedure and associated risk. Sufficient detail should be recorded in a patient record to reflect the associated information on treatment options and the agreed treatment plan proposed to the patient. A written treatment plan should be provided to the patient where complex or high risk procedures are to be undertaken.</td>
<td>Revise title of indicator to ‘Client / carer engagement in care’ Revise description to ‘The proportion of clients (and/or carers) who have discussed information about the purpose, treatment options, benefits, risks and costs of care, with a...’</td>
<td>21</td>
<td></td>
</tr>
</tbody>
</table>
### Dimension Candidate indicators

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Candidate indicators</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Practitioner</td>
<td>Informed consent for treatment</td>
<td>Applicable – high (Dr Murray Thomas) The Informed consent for treatment description does not measure informed consent. (NMP) Informed consent is difficult to assess: delivery of requisite information does not necessarily mean the patient has understood the information. (RACP) It is unclear to us how this would be measurable in settings like a pharmacy. (NPS) Agreed. Recommend including advocates where patients required assistance to respond. The words ‘had information’ and ‘discussed’ are open to interpretation. There are medico-legal guidelines for the provision of informed consent – perhaps these can guide improved wording for this. (SA Health) Unclear how this would this be measured although it could include both a patient and/or clinician survey. Determining “informed consent” can be difficult as signing a consent form does not always equal understanding of the information. However, this becomes less of an issue if the changes proposed above to indicator 15 are made. (AGPN)</td>
</tr>
<tr>
<td>Effectiveness</td>
<td>Patient improvement</td>
<td>The proportion of regular patients whose condition has improved, measured using a validated tool or clinical guideline (for conditions where improvement is expected, e.g. diabetes, weight reduction, smoking cessation) This may well be the key indicator but the measure must be objective. BMI, HbA1c, cholesterol, blood pressure would be ideal (J Stafford) [Add to examples] adherence to medicines. (Heart Foundation) Patients with chronic disease generally do not improve, the usual target is to stabilise. This area is especially important to define clinical targets and compare to like services regionally and nationally (NT DoH) The dental related disease indexes available includes: • indication of home oral hygiene proficiency eg Plaque Index • history and status of hard tissue disease eg Decayed Missing and Filled Teeth or Surfaces • history and status of soft tissue disease eg Periodontal Index of Treatment Needs • testing saliva eg quantify and pH ad buffering capacity • nutritional indications eg food frequency assessment A major challenge to a practice will be transforming the use of indexes for an individual patient to collecting and analysing the data for the practice population. Applicable – low (Dr Murray Thomas) Difficult to assess for some conditions. Stability of condition (non-deterioration) may be more meaningful. (PSA) Patient improvement is highly dependent on socio-cultural status. The description is too broad and ambitious and needs to be more specific. In respect of diabetic care, the management of this disease is more effectively measured by having complications screened - for example, cholesterol levels, blood pressure measurement - rather than how well the disease is controlled (to overcome the fact that the higher the dose of insulin, the higher the BMI in general). (RACP) Indicator 22 while well constructed assumes the existence of validated tools and guidelines in areas of primary healthcare. While this indicator is worth having to signal the way in which services should ideally measure effectiveness the ability of services to apply this indicator may be limited in many areas. Future research would be welcome in the areas of identifying validated self rated health status instrument that are useful and sensitive enough to measure change at the individual client level and/or funded program level. (VHA) APNA recommends that the ACSQHC review indicator 22.</td>
</tr>
</tbody>
</table>

**Recommendation**

<table>
<thead>
<tr>
<th>#</th>
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<tbody>
<tr>
<td>health practitioner'</td>
<td></td>
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</table>

Note: The above table is a synthesis of submissions on the consultation paper and recommended national indicator set.
### Dimension Candidate indicators

<table>
<thead>
<tr>
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</tr>
</thead>
</table>
| Goals of care attainment  |                      | and reduce its scope to circumstances where there is a strong and direct link between provider intervention and patient outcome that is effectively uncontaminated by the patient role. (APNA)  
Agreement in principle. Suggestion that for some patients with very advanced age, or a condition (s) or complexity where deterioration is the expected course, that maintenance or stabilization of their function, mobility and quality of life / social wellbeing indicate that the therapeutic intervention and the care plan have considerable effectiveness. (SA Health)  
We already collect some of this data e.g. Hba1c, smoking status and a ML could aggregate this practice-level data. But conditions such as diabetes are a progressive disease so some parameters would be expected to deteriorate anyway. (Melbourne East GP Network)  
The proportion of regular clients whose condition has improved, or stabilised (for conditions where improvement of stabilisation is expected) as measured through a validated self rated health status instrument that informs their individual care. | New indicator B |
| Goals of care partially attained |                      | The proportion of goals met in the timeframe stated for attainment of each goal for patients with a care plan  
Best to present not just the “best group” but the range of outcomes achieved (good, OK, poor and lousy) presented in tabular form, with the incentive being to move as many people as possible at least one notch in the direction of improvement. (NT DoH)  
The College questions the usefulness of these indicators as primary care professionals cannot be expected to take responsibility for these when patients may choose not to follow the care plans (RACGP)  
Dentistry can offer very predictable and successful treatment regimens for oral disease. However, once the execution phase of treatment has been completed the overwhelming responsibility for maintaining oral health rests with the patient and their ability and willingness to adhere to proven home care regimes.  
Dental treatment plans use an execution phase of active treatment to restore soft tissue health, function and aesthetics that will enable a patient to enter into an ongoing maintenance phase.  
The formulated plans may be simple to complex including the use of interdisciplinary approaches. The uptake of dental treatment plan by a patient may vary dramatically dependent on a number of factors including the type of practice eg specialist versus general, services offered, patient expectation and financial considerations.  
The time frames for attainment of care goals can vary considerable between patents undertaking similar treatment due to level of patient cooperation or financial constraints. Applicable – medium (Dr Murray Thomas)  
APNA recommends that the ACSQHC review indicator 23, and reduce its scope to circumstances where there is a strong and direct link between provider intervention and patient outcome that is effectively uncontaminated by the patient role. (APNA)  
Agreed, assuming that these are patient’s goals. (SA Health)  
This indicator looks very like indicators 10 and 22. (J Stafford)  
The proportion of goals partially met in the timeframe stated for attainment of each goal, or appropriately renegotiated, for patients with a care plan  
See 23 (NT DoH)  
The College questions the usefulness of these indicators as | Retain Replace ‘patients’ with ‘clients’ | 23 |

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**AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE**  
*Practice-level indicators of safety and quality for primary health care*  
*Synthesis of submissions on the consultation paper and recommended national indicator set*  
TRIM 55548  
DRAFT Version 3.0  
Page 43 of 63
### Synthesis of submissions on the consultation paper and recommended national indicator set

<table>
<thead>
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<tbody>
<tr>
<td>primary care professionals cannot be expected to take responsibility for these when patients may choose not to follow the care plans (RACGP)</td>
<td>High relevance to government and NFP agencies delivering dental services. A patient treated within a private practice exercises considerable influence on the pace of achieving treatment goals. These circumstances are usual beyond the dental practitioner’s control. The financial implications of uncompleted treatment plans are a powerful additional driver for a dental practitioner to ensure agreed treatment plans are completed. Applicable – low (Dr Murray Thomas) APNA recommends that the ACSQHC review indicator 22, and reduce its scope to circumstances where there is a strong and direct link between provider intervention and patient outcome that is effectively uncontaminated by the patient role. Indicator 24 has two elements – the partial meeting of the goals AND their renegotiation which makes the definition of the indicator unclear. (APNA) Agreed, assuming that these are patient’s goals. (SA Health)</td>
<td>Clarify essential elements of a care plan, including client stated/agreed issues/problems and client stated/agreed objectives/goals</td>
<td></td>
</tr>
<tr>
<td>Coordination of care</td>
<td>Referral process</td>
<td>The proportion of practice referrals that are issued in accordance with the practice’s policy for referral processes (for appropriateness and timeliness) This referral should be against national standards rather than local ones (J Stafford) Not supported (NT DoH) Applicable – high (Dr Murray Thomas) Does not address the need for proactive referral to address needs identified where the need is outside the provider’s scope of practice (ISCHS) Agreed (SA Health) This could be extended to include referrals that are received and acted upon also although may be better covered in the “accessibility” section. (AGPN)</td>
<td>Retain</td>
</tr>
<tr>
<td>Referral content</td>
<td>The proportion of practice referrals that contained appropriate identifying, clinical and contact information and a current medication list Not sure how objective this can be made (J Stafford) Not supported (NT DoH) A clear definition will be required for ‘appropriate’ (RACGP) Applicable – high (Dr Murray Thomas) Agreed. Referral should be considered as a type of clinical handover with established standards for the exchange of information and responsibility of care. The content should support care coordination between services and also with the patient / carer. (SA Health) A ML could audit patient files to review content of referrals but this raises issues of patient privacy and the willingness of practices to allow outside agencies to do this. It would also be time consuming. The benefit for a practice would need to be found to gain cooperation. (Melbourne East GP Network) “Appropriate information” needs to be defined and standardised. (AGPN)</td>
<td>Retain</td>
<td></td>
</tr>
<tr>
<td>Allocation of a ‘key contact’ person/case manager</td>
<td>The proportion of patients with multiple or complex needs who are allocated a ‘key contact person’ or care coordinator, and are given their contact details The GP will remain the ultimate care coordinator. I don’t think this indicator has a lot of value (J Stafford) Not supported (NT DoH) A dental practitioner does not ‘medically manage’ a patient but may operate within a virtual interdisciplinary team as part of a patient’s ‘health neighbourhood’ eg Chronic Disease Dental Scheme. Not applicable</td>
<td>Retain</td>
<td></td>
</tr>
</tbody>
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**Table Note:***

- **Recommendation:**
  - Retain
  - Revise
  - Clarify
- **#** indicates the indicator number in the Australian Commission on Safety and Quality in Health Care (ACSQHC) indicator set.
## Synthesis of submissions on the consultation paper and recommended national indicator set

<table>
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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Dimension Candidate indicators</td>
<td></td>
<td><strong>Alternate Indicator</strong>&lt;br&gt;The proportion of patients accepted under care plans that have complete documentation in their records. (Dr Murray Thomas)&lt;br&gt;Agreement. This will depend on the existence of models of care across and between services that ensure that a care coordinator is recognised in that role, by service providers, patient and carer. (SA Health)</td>
<td>or care coordinator, according to locally agreed guidelines, and are given their contact details*</td>
</tr>
<tr>
<td>Timely communication to health practitioners</td>
<td></td>
<td><strong>Alternate Indicator</strong>&lt;br&gt;The proportion of patients where timely reporting of care assessments or outcomes was communicated to the patient’s GP or specialist doctor.&lt;br&gt;Whilst I support the intent of this indicator, I am unsure how it will be measured (J Stafford)&lt;br&gt;Supported, but this would be especially useful if communication from the hospital to primary health care at the time of discharge was also monitored (NT DoH)&lt;br&gt;Government expenditure within the overall dental expenditure is relatively small but a dental practice may choose to participate in government schemes where compliance matters arise relating to care assessments. The dominate issues in these circumstances related to administrative matters and financial remuneration eg Chronic Diseases Dental Scheme.&lt;br&gt;Applicable – medium (Dr Murray Thomas)&lt;br&gt;Change to include timeliness of communication to other Practitioner’s involved in the client’s care (ISCHS)&lt;br&gt;The description should be expanded to include communication to all those involved in the consumers care, including the consumer. (NMP)&lt;br&gt;Agreement in principle, although this somewhat assumes that the GP / specialist doctor has assumed the role of care coordinator. The care coordinator and patient / carer may also need this information. In essence, the right people need the right information – a challenge to measure. Suggestion to replace the ‘reporting of care assessments or outcomes’ with ‘sharing of assessment findings, goals and care plan’ to be consistent with earlier indicators. (SA Health)&lt;br&gt;(1) “Timely” needs to be defined; and (2) Suggest broaden this communication to include more than GP and specialist doctors. Communication of patient assessments and outcomes should occur between all relevant health care team members. (AGPN)</td>
<td>Retain&lt;br&gt;Revise title to “Timely communication to health practitioners”&lt;br&gt;Revise description to “The proportion of clients where timely reporting of care assessments or outcomes was communicated to all relevant health care practitioners involved in the patient’s care”&lt;br&gt;Clarify ‘all relevant health care practitioners involved in the patient’s care’&lt;br&gt;Clarify ‘timely’</td>
</tr>
<tr>
<td>Timely review and follow-up of diagnostic results</td>
<td></td>
<td><strong>Alternate Indicator</strong>&lt;br&gt;The proportion of patients whose diagnostic results were reviewed by a clinician and acted on in a timely manner in accordance with agreed clinical guidelines. Seem to cross over other indicators (9, 10, 11) (J Stafford)&lt;br&gt;Supported (NT DoH)&lt;br&gt;Most of diagnostic tests for patients referred by a dental practitioner will relate to radiography tests with some pathology testing. No current national or professional guidelines for dental practice are available.&lt;br&gt;Applicable – medium (Dr Murray Thomas)&lt;br&gt;There are not many clinical guidelines related to timeframes for reviewing patients. (RACP)&lt;br&gt;Agreed. Suggestion to replace ‘diagnostic results’ with ‘diagnostic results and assessment findings’. SA Health&lt;br&gt;Expand to include both ‘clinical and professional guidelines’ to reflect the many, freely available guidelines (gpns)&lt;br&gt;“Timely” needs to be defined and standardised. (AGPN)</td>
<td>Retain&lt;br&gt;Revise description to “The proportion of clients whose diagnostic results were reviewed by a health practitioner and acted on in a timely manner in accordance with agreed guidelines”&lt;br&gt;Clarify ‘timely’</td>
</tr>
<tr>
<td>Medication reconciliation</td>
<td></td>
<td><strong>Alternate Indicator</strong>&lt;br&gt;The proportion of patients whose medication list has been reconciled against the service’s patient health record&lt;br&gt;Agreed (SA Health)&lt;br&gt;More important medication issues such as the proportion of scripts filled or medication regimes followed… could be</td>
<td>Retain&lt;br&gt;Replace ‘patients’ with ‘clients’</td>
</tr>
</tbody>
</table>

*SA Health: South Australia Department of Health

**J Stafford:** Jane Stafford

**NT DoH:** Northern Territory Department of Health

**RACP:** Royal Australian College of Physicians

**ISCHS:** Integrated Primary Health Care Services

**NMP:** National Medical Practice

**AGPN:** Australian General Practice Network
### Practice-level indicators of safety and quality for primary health care

**Synthesis of submissions on the consultation paper and recommended national indicator set**

<table>
<thead>
<tr>
<th>Dimension</th>
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</tr>
</thead>
</table>
|             | **removed (J Stafford)** Supported although not relevant with most practice software** (NT DoH) | A medicines review is a structured evaluation of a patient’s medicines, including alternative and over the counter preparations, to identify:  
* significant potential drug interactions  
* important potential side effects  
* significant potential impacts on health outcomes  
* significant implications for oral health care planning and treatment  
Significant findings should be recorded in the patient record. Not applicable | Include clarification of medication reconciliation, as follows  
"Medication reconciliation is a formal process of obtaining and verifying a complete and accurate list of each patient's current medicines, and matching the medicines the patient should be prescribed to those they are actually prescribed. Where there are discrepancies, these are discussed with the prescriber and reasons for changes to therapy are documented"[22] | 27 |
|             | **Alternate Indicator** The proportion of patients whose medication history was reviewed and updated at the last dental examination.** (Dr Murray Thomas) | Doctor-centric measure, will have limited usefulness in primary health care for services such as pharmacy practice (PSA)  
Medication reconciliation is dependent on hospitals/facilities/patient to provide this information rather than a General Practice. (RACP) | Supported (NT DoH)  
Applicable – high (Dr Murray Thomas)  
The description should be expanded to outline that these reactions may also need to be formally reported via the appropriate reporting processes. (NMP)  
Documentation of adverse drug events/allergies in the service’s patient health record is dependent on whether hospitals communicate the information to the general practitioner. In terms of the ACSQHC definition of primary health care, allied health professionals might not document reactions/allergies. Not many primary care practices have incident reporting systems. (RACP)  
We suggest expanding this to encompass the patient health record, the patient health summary and medicines list. (NPS)  
Agreed, with acknowledgement that only those primary health care services that are involved in prescribing medications will require this information. Suggestion that ‘known adverse drug reactions and medication allergies’ is replaced by ‘known adverse drug reactions, medication allergies and infection status’. (SA Health)  
This data is required in general practice for accreditation, but would require resources to go into practices to review patient files. This raises issues of patient privacy and the willingness of practices to allow outside agencies to do this. The benefit for a practice would need to be found to gain cooperation. (Melbourne East GP Network)  
This appears to duplicate indicator 5 (AGPN) | Replace ‘patients’ with ‘clients’  
Retain | 31 |
<p>| Patient safety | The proportion of the service’s documented patient safety | | Retain | 32 |</p>
<table>
<thead>
<tr>
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<th>Description</th>
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<th>#</th>
</tr>
</thead>
</table>
| incidents investigations|                      | incidents (i.e. near misses or errors, and adverse events that result in harm) where an investigation has been completed in accordance with local policy  
I wonder how relevant this indicator is and how it will be measured. It seems very subjective (J Stafford)  
Supported (NT DoH)  
This indicator has high application to government and large multi-clinic practices.  
The number of potential incidents in the majority of dental practices will be relatively small based on 5,000 appointments per year per dental practitioner with an indicative error rate of 25 per 100,000. This indicator lacks practical application in micro healthcare settings. The expectation should be that all incidents investigations have been completed.  
Applicable – low (Dr Murray Thomas)  
Agreed (SA Health) | Retain                  | 33                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                |    |
| Patient safety incidents follow-up |                      | The proportion of the service’s documented patient safety incidents (i.e. near misses or errors, and adverse events that result in harm) where action is taken to reduce risks identified through the investigation  
I wonder how relevant this indicator is and how it will be measured. It seems very subjective (J Stafford)  
Supported (NT DoH)  
This appears to duplicate the intention of the NSQHS Standard 1.14.4 Action is taken to reduce risks to patients identified through the incident management system  
This indicator has high application to government and large multi-clinic practices.  
The number of potential incidents in the majority of dental practices will be relatively small based on 5,000 appointments per year per dental practitioner with an indicative error rate of 25 per 100,000. This indicator lacks practical application in healthcare settings with small workforce. The expectation should be that all incidents have been completed.  
Applicable – low (Dr Murray Thomas)  
Agreed (SA Health) | Retain                  | 33                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                |    |
| Infection control       |                      | The proportion of the service’s eligible workforce who have received infection control training within the previous 12 months  
This is a process indicator and has little value as a quality measure. (J Stafford)  
Generally support, but twelve months is too frequent.  
Probably 2 years for staff training (NT DoH)  
High relevance to government and large multi-clinic practices. This indicator lacks practical application in micro-healthcare settings with a small workforce. Applicable – low (Dr Murray Thomas)  
The infection control description does not measure actual infection rates or the processes to avoid infection rates.(NMP)  
Agreed (SA Health)  
We already document which practice staff (eligible workforce) who have received infection control training in the previous 12 months. (Melbourne East GP Network) | Retain                  | 34                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                |    |
8 Recommended national set

The recommended national set of practice-level indicators of safety and quality are listed in Table 6 below.

Table 6: Recommended national set of practice-level indicators of safety and quality for primary health care

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Candidate indicators</th>
<th>Description</th>
<th>#</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accessibility</td>
<td>First contact to service wait time</td>
<td>The proportion of clients whose wait from first contact to first service is within the locally agreed timeframe</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>First contact to service wait time for high-priority clients</td>
<td>The proportion of clients who are high priority according to locally agreed criteria, and whose wait from first contact to first service is within the locally agreed timeframe</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Eligible clients who received an appointment</td>
<td>The proportion of eligible clients requesting an appointment who received an appointment</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Non-attendance at appointment</td>
<td>The proportion of clients who did not arrive for an appointment, and who were followed-up</td>
<td>4</td>
</tr>
<tr>
<td>Appropriateness</td>
<td>Health summary</td>
<td>The proportion of regular clients with a comprehensive health summary, including information on allergies, current/past medical history, medications and risk factors, which was updated within the previous 12 months</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Timely initial needs identification</td>
<td>The proportion of clients whose initial needs identification was conducted, within the locally agreed timeframe</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Client assessment</td>
<td>The proportion of clients assessed, using validated assessment and screening tools appropriate to the scope of practice and the client's needs</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Complete care plan</td>
<td>The proportion of clients with multiple or complex needs who have a complete care plan</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Recalls and reminders</td>
<td>The proportion of clients with a complete care plan who were given recalls or reminders as recommended in the care plan</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Adherence to clinical guidelines</td>
<td>The proportion of clients with complete care plans that are in accordance with agreed clinical guidelines</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Timely review of care plan</td>
<td>The proportion of clients with a recorded care plan that is reviewed by the planned review date</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>Medication review</td>
<td>The proportion of regular clients whose medicines have been reviewed by a health practitioner in accordance with locally agreed guidelines</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>Interpreter services</td>
<td>The proportion of clients requiring an interpreter who were provided with interpreter services at the first service</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>Cultural and linguistic diversity awareness/sensitivity</td>
<td>The proportion of the service’s eligible workforce who have received cultural competency training</td>
<td>14</td>
</tr>
<tr>
<td>Acceptability/patient participation</td>
<td>Self-rated health</td>
<td>The proportion of regular clients who have completed a validated self-rated health status instrument that informs their health care</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Patient experience survey</td>
<td>The proportion of regular clients who have been given a patient experience survey within the previous 12 months. (using a standard patient experience instrument that informs the service’s quality)</td>
<td>16</td>
</tr>
</tbody>
</table>
### Dimension Candidate indicators | Description | #
--- | --- | ---
**Patient experience** | **survey response rate** | The proportion of regular clients who have responded to a patient experience survey within the previous 12 months (using a standard patient experience instrument, that informs the service’s quality improvement) | 17
**Satisfaction with patient experience** | | The proportion of regular clients who are very satisfied with specified elements of their patient experience within the previous 12 months (using a standard patient experience instrument) | 18
**Client / carer complaints response** | | The proportion of client and carer complaints responded to within the service’s nominated timeframe from receipt of complaint | 19
**Client partnership in quality improvement** | | The proportion of clients who have been invited to contribute to quality improvement activities based on the results of the patient experience survey | 20*
**Client / carer engagement in care** | | The proportion of clients (and/or carers) who have discussed information about the purpose, treatment options, benefits, risks and costs of care, with a health practitioner | 21
**Effectiveness** | **Client improvement / stabilisation** | The proportion of regular clients whose condition has improved, or stabilised (for conditions where improvement or stabilisation is expected) | 22
**Self-rated client improvement / stabilisation** | | The proportion of regular clients whose condition has improved, or stabilised (for conditions where improvement of stabilisation is expected) as measured through a validated self rated health status instrument that informs their individual care. | 23*
**Goals of care attainment** | | The proportion of goals met in the timeframe stated for attainment of each goal, for clients with a care plan | 24
**Goals of care partially attained** | | The proportion of goals partially met in the timeframe stated for attainment of each goal, or appropriately renegotiated, for clients with a care plan | 25
**Coordination of care** | **Referral process** | The proportion of service referrals that are made in accordance with the service’s policy for referral processes (for appropriateness and timeliness) | 26
**Referral content** | | The proportion of service referrals that contain appropriate identifying, clinical and contact information and a current medication list | 27
**Allocation of a ‘key contact’ person/case manager** | | The proportion of clients with multiple or complex needs who are allocated a ‘key contact person’ or care coordinator, according to locally agreed guidelines, and are given their contact details | 28
**Timely communication to health practitioners** | | The proportion of clients where timely reporting of care assessments or outcomes was communicated to all relevant health care practitioners involved in the client’s care | 29
**Continuity of care** | **Timely review and follow-up of diagnostic results** | The proportion of clients whose diagnostic results were reviewed by a health practitioner and acted on in a timely manner in accordance with agreed guidelines | 30
**Medication reconciliation** | | The proportion of clients whose medication list has been reconciled against the service’s patient health record | 31
**Safety** | **Adverse drug** | The proportion of clients whose known adverse drug | 32
### Dimension Candidate indicators Description #

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Candidate indicators</th>
<th>Description</th>
<th>#</th>
</tr>
</thead>
<tbody>
<tr>
<td>reactions and medication allergies</td>
<td>reactions and medication allergies are documented in the service’s patient health record</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient safety incidents investigations</td>
<td>The proportion of the service’s documented patient safety incidents (i.e. near misses or errors, and adverse events that result in harm) where an investigation has been completed in accordance with local policy</td>
<td>33</td>
<td></td>
</tr>
<tr>
<td>Patient safety incidents follow-up</td>
<td>The proportion of the service’s documented patient safety incidents (i.e. near misses or errors, and adverse events that result in harm) where action is taken to reduce risks identified through the investigation</td>
<td>34</td>
<td></td>
</tr>
<tr>
<td>Infection control</td>
<td>The proportion of the service’s eligible workforce who have received infection control training within the previous 12 months</td>
<td>35</td>
<td></td>
</tr>
</tbody>
</table>

* new indicator
REFERENCES


5. eHealth Services Research Group University of Tasmania. ‘Report on practice level indicators of safety and quality in primary health care including a literature review and environmental scan’. Report to the Australian Commission on Safety and Quality in Health Care, not published.


16. OECD. Health care quality indicators. (www.oecd.org/document/34/0,3746,en_2649_37407_37088930_1_1_1_37407,00.html)


Synthesis of submissions on the consultation paper and recommended national indicator set


22. Australian Commission on Safety and Quality in Health Care

APPENDIX 1 — INDICATOR DEVELOPMENT PROCESS

The Commission will follow a consistent process to select and design suites of national safety and quality indicators, as set out below.

1. Identify quality-related issues of importance to consumers, expert clinical groups, healthcare providers and policy experts.

2. Undertake a scan of national and international literature, existing indicator sets and issues in quality indicator development for the particular clinical domain/s of interest.

3. Review and refine a candidate set of indicators derived from the scan through workshop/s with experts including clinicians, policy makers and healthcare providers.
   a) Evaluate the potential indicators for rationale and importance against strategic criteria; for example
      - health expenditure
      - disease burden (i.e. domains that represent a significant burden of incidence and provision of care)
      - compliance with ministerial, legislative and policy obligations
      - alignment with quality dimensions of strategic importance
      - structure, process and outcomes
   b) Evaluate the potential indicators against the technical criteria for selection of quality indicators. Effective indicators that will engage clinicians and health service managers in quality improvement should have a number of consistently agreed characteristics. They should be [12]:
      - definable, based on definitions that are not ambiguous
      - supported by a clear rationale for collection and reporting
      - relevant to clinicians, health service managers and stakeholders
      - feasible to collect, minimising the burden of data collection
      - reliable (i.e. results are reproducible)
      - valid (i.e. measures what it is intended to measure)
      - responsive (i.e. signals action)
      - comparable
      - sensitive to change
      - free from unintended consequences.
   c) Evaluate the potential indicators for feasibility of data availability, as well as the likely administrative and financial burden to collect and report the data.

4. Develop technical specifications using the standard indicator template to document the selected set, including, where appropriate, rationale, definition, numerator, denominator, computation, risk adjustment, disaggregation, presentation and data source.
5. Undertake consultation processes (online and national workshop) on the draft indicator set (similar to that used by Colleges, the Australian Council on Healthcare Standards and jurisdictions in development of clinical indicator sets).

6. Review and finalise indicator specifications for publication.
APPENDIX 2 — RELEVANT INDICATOR FRAMEWORKS

An initial aim of this project was to categorise and define primary health care clinical domains to assist the development of the national set of practice-level indicators of safety and quality for primary health care.

The intention was to provide a framework for the candidate indicator set that reflects both the nature of primary health care and the health needs of primary care patients, as well as the dimensions of quality (appropriateness, effectiveness, accessibility, consumer participation, efficiency and safety), and the commonly used classification for quality indicators consisting of structure, process or outcome, as first developed by Donabedian. [19]

‘A conceptual health indicator framework can inform the selection and interpretation of meaningful health indicators. Such a framework identifies what information is needed to address questions about health and health care, how these pieces fit together and the inter-relationships between them’. [1]

As background information, this section provides an overview of several frameworks for conceptualising primary health care, health indicators and quality indicators.

1 Dimensions of primary care

Kringos et al have identified ten core dimensions of primary care within Donabedian’s classification for indicators: structure, process and outcome (see Table A below). The aim of the Kringos study was to explore the breadth of primary care, identify its core dimensions, and assess their interrelations and relevance to outcomes at system level. [2]

Table A: Dimensions of primary care

<table>
<thead>
<tr>
<th>DIMENSIONS</th>
<th>SUB-DIMENSIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>STRUCTURE</td>
<td>Governance</td>
</tr>
<tr>
<td></td>
<td>Economic conditions</td>
</tr>
<tr>
<td></td>
<td>Workforce development</td>
</tr>
<tr>
<td>PROCESS</td>
<td>Access</td>
</tr>
<tr>
<td></td>
<td>Continuity of care</td>
</tr>
<tr>
<td></td>
<td>Coordination of care</td>
</tr>
<tr>
<td></td>
<td>Comprehensiveness of care</td>
</tr>
<tr>
<td>OUTCOME</td>
<td>Quality of care</td>
</tr>
<tr>
<td></td>
<td>Efficiency of care</td>
</tr>
<tr>
<td></td>
<td>Equity in health</td>
</tr>
</tbody>
</table>

Structure indicators include organisational aspects of health care and the ‘attributes of the settings in which care occurs’. Process indicators reflect actions of healthcare professionals and organisations (i.e. what is ‘done in giving and receiving care’). Process indicators may be based on recommended actions in clinical guidelines, professional experience or scientific literature. Outcome indicators describe the results or ‘effects of care’ on the health of patients and populations. [20, 21] Donabedian argued that the most important markers of quality care were healthcare outcomes, ‘but that these outcomes were more likely to be realised if structural arrangements and processes of care met quality standards’. [7]
2 ISO/FDIS 21667:2010 — Health Indicators Conceptual Framework

This Standard provides a comprehensive and broad (high-level) classification (see Table B) which was developed by the ISO Technical Committee for Health Informatics (TC 215), to describe all of the factors related to health outcomes and health system performance and use. The Standard allows for operation in different ways by individual jurisdictions, and supports flexibility for the selection of specific indicators and future inclusion of new indicators. [1]

Table B: Health indicators conceptual framework [1]

<table>
<thead>
<tr>
<th>DIMENSIONS</th>
<th>SUB-DIMENSIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>HEALTH STATUS</td>
<td></td>
</tr>
<tr>
<td>Wellbeing</td>
<td>Health conditions</td>
</tr>
<tr>
<td>Human function</td>
<td>Deaths</td>
</tr>
<tr>
<td>DETERMINANTS OF HEALTH</td>
<td></td>
</tr>
<tr>
<td>Health behaviours</td>
<td>Socioeconomic factors</td>
</tr>
<tr>
<td>Social and community factors</td>
<td>Environmental factors</td>
</tr>
<tr>
<td>Genetic factors</td>
<td></td>
</tr>
<tr>
<td>HEALTH SYSTEM PERFORMANCE</td>
<td></td>
</tr>
<tr>
<td>Acceptability</td>
<td>Accessibility</td>
</tr>
<tr>
<td>Appropriateness</td>
<td>Competence</td>
</tr>
<tr>
<td>Continuity of care</td>
<td>Effectiveness</td>
</tr>
<tr>
<td>Efficiency</td>
<td>Safety</td>
</tr>
<tr>
<td>COMMUNITY AND HEALTH SYSTEM CHARACTERISTICS</td>
<td>Resources</td>
</tr>
<tr>
<td>Population</td>
<td>Health system characteristics</td>
</tr>
</tbody>
</table>
4 Clinical governance indicators for community health

The Victorian Healthcare Association (VHA) has developed indicators for benchmarking in Victorian community health services (for examples, see Table D).

Table D: Indicators for community health [18]

<table>
<thead>
<tr>
<th>DIMENSIONS</th>
<th>INDICATORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>ENTRY</td>
<td>% of clients with initial needs identification (INI)</td>
</tr>
<tr>
<td></td>
<td>% of clients with INI commenced within no more than 7 working days of initial contact</td>
</tr>
<tr>
<td></td>
<td>Average length of wait for high-priority category clients to mandated services</td>
</tr>
<tr>
<td></td>
<td>% of clients requiring interpreter receiving interpreter</td>
</tr>
<tr>
<td>CARE</td>
<td>Complete care plans</td>
</tr>
<tr>
<td></td>
<td>Incomplete care plans</td>
</tr>
<tr>
<td></td>
<td>Objectives</td>
</tr>
<tr>
<td></td>
<td>Care plan review</td>
</tr>
<tr>
<td>CONTINUITY OF CARE</td>
<td>Communication to GP</td>
</tr>
<tr>
<td></td>
<td>Reason for incomplete care plans</td>
</tr>
<tr>
<td></td>
<td>Goals attainment</td>
</tr>
<tr>
<td></td>
<td>Goals of care partially attained</td>
</tr>
</tbody>
</table>

Note: VHA have also developed a Diabetes Care Indicator Set, an Oral Health Indicator Set, an Incident Set and indicators related to consent for disclosure, staff and complaints.
The RACGP have developed *Standards for General Practice* (see Table E [17]), which are supported by criteria and indicators. These Standards provide a framework for the continuing development of well-performing practice teams to enable them to focus on quality care and risk management.

**Table E: Standards for general practice [17]**

<table>
<thead>
<tr>
<th>DIMENSIONS</th>
<th>Standard and criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PRACTICE SERVICES</strong></td>
<td><strong>Access to care:</strong> scheduling care in opening hours; telephone and electronic communications; home and other visits; care outside normal opening hours</td>
</tr>
<tr>
<td></td>
<td><strong>Information about the practice:</strong> practice information; informed patient decisions; interpreter and other communication services; costs associated with care initiated by the practice</td>
</tr>
<tr>
<td></td>
<td><strong>Health promotion and prevention of disease:</strong> health promotion and preventive care</td>
</tr>
<tr>
<td></td>
<td><strong>Diagnosis and management of health problems:</strong> consistent evidence-based practice; clinical autonomy for general practitioners</td>
</tr>
<tr>
<td></td>
<td><strong>Continuity of care:</strong> continuity of comprehensive care and the therapeutic relationship; clinical handover; system for follow-up of tests and results</td>
</tr>
<tr>
<td></td>
<td><strong>Coordination of care:</strong> engaging with other services; referral documents</td>
</tr>
<tr>
<td></td>
<td><strong>Content of patient health record:</strong> patient health records; health summaries; consultation notes</td>
</tr>
<tr>
<td><strong>RIGHTS AND NEEDS OF PATIENTS</strong></td>
<td><strong>Collaborating with patients:</strong> respectful and culturally appropriate care; patient feedback (experience); presence of a third party</td>
</tr>
<tr>
<td><strong>SAFETY, QUALITY IMPROVEMENT AND EDUCATION</strong></td>
<td><strong>Safety and quality:</strong> quality improvement activities; clinical risk management systems; clinical governance; patient identification</td>
</tr>
<tr>
<td></td>
<td><strong>Education and training:</strong> qualifications of general practitioners; qualifications of clinical staff other than medical practitioners; training of administrative staff</td>
</tr>
<tr>
<td><strong>PRACTICE MANAGEMENT</strong></td>
<td><strong>Practice systems:</strong> human resource system; occupational health and safety</td>
</tr>
<tr>
<td></td>
<td><strong>Management of health information:</strong> confidentiality and privacy of health information; information security</td>
</tr>
<tr>
<td><strong>PHYSICAL FACTORS</strong></td>
<td><strong>Facilities and access:</strong> practice facilities; physical conditions conducive to confidentiality and privacy; physical access</td>
</tr>
<tr>
<td></td>
<td><strong>Equipment for comprehensive care:</strong> practice equipment; doctor’s bag</td>
</tr>
<tr>
<td></td>
<td><strong>Clinical support processes:</strong> safe and quality use of medicines; vaccine potency; healthcare associated infections</td>
</tr>
</tbody>
</table>
6 Framework for practice-level indicators of safety and quality for primary health care

The framework for the indicator set has been adapted from the ISO Health Indicators Conceptual Framework, and also incorporates the process and outcome dimensions of primary health care as defined by Kringos et al. Examples in the framework in Table F have been drawn from the research and consultations.

Table F: Framework for practice-level indicators of safety and quality for primary health care

<table>
<thead>
<tr>
<th>DIMENSIONS</th>
<th>Coordination of care</th>
<th>Accessibility</th>
<th>Appropriateness</th>
<th>Acceptability/ consumer participation</th>
</tr>
</thead>
<tbody>
<tr>
<td>e.g. referrals,</td>
<td>e.g. time to</td>
<td>e.g. interpreter services, complete care plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>communication to</td>
<td>appointment/treatment,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>general practitioner</td>
<td>% of target group</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>attending for</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>screening</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Continuity of care</th>
<th>Effectiveness</th>
<th>Safety</th>
</tr>
</thead>
<tbody>
<tr>
<td>e.g. medication</td>
<td>e.g. smoking</td>
<td>e.g. infection control training, patient identification, adverse drug reactions</td>
</tr>
<tr>
<td>review, review and</td>
<td>cessation</td>
<td></td>
</tr>
<tr>
<td>follow-up of</td>
<td>during</td>
<td></td>
</tr>
<tr>
<td>diagnostic</td>
<td>pregnancy</td>
<td></td>
</tr>
<tr>
<td>results</td>
<td>patient</td>
<td></td>
</tr>
<tr>
<td></td>
<td>improvement</td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX 3 — National Safety and Quality Health Service Standards

The National Safety and Quality Health Service (NSQHS) Standards focus on areas that are essential to improving the safety and quality of care for patients. The NSQHS Standards aim to protect the public from harm and to improve the quality of health service provision. [13]

The ten National Safety and Quality Health Service Standards are:

1. **Governance for safety and quality in health service organisations**, which describes the quality framework required for health service organisations to implement safe systems.

2. **Partnering with consumers**, which describes the systems and strategies to create a consumer-centred health system by including consumers in the development and design of quality health care.

3. **Preventing and controlling healthcare associated infection**, which describes the systems and strategies to prevent infection of patients within the healthcare system and to manage infections effectively when they occur to minimise the consequences.

4. **Medication safety**, which describes the systems and strategies to ensure clinicians safely prescribe, dispense and administer appropriate medicines to informed patients.

5. **Patient identification and procedure matching**, which describes the systems and strategies to identify patients and correctly match their identity with the correct treatment.

6. **Clinical handover**, which describes the systems and strategies for effective clinical communication whenever accountability and responsibility for a patient’s care is transferred.

7. **Blood and blood products**, which describes the systems and strategies for the safe, effective and appropriate management of blood and blood products so the patients receiving blood are safe.

8. **Preventing and managing pressure injuries**, which describes the systems and strategies to prevent patients developing pressure ulcers and best practice management when pressure injuries occur.

9. **Recognising and responding to clinical deterioration in acute health care**, which describes the systems and processes to be implemented by health service organisations to respond effectively to patients when their clinical condition deteriorates.

10. **Preventing falls and harm from falls**, which describes the systems and strategies to reduce the incidence of patient falls in health service organisations and best practice management when falls do occur.
APPENDIX 4 —Details of the consultation process

1 Focus groups held in March 2011

The following organisations and committees were represented:

- Australian College of Midwives
- Australian College of Rural and Remote Medicine
- Royal College of Nursing Australia
- Congress of Aboriginal and Torres Strait Islander Nurses
- Palliative Care Australia
- Health Consumers of Rural and Remote Australia
- Improvement Foundation
- National Prescribing Service
- National Primary and Community Health Network
- The Royal Australian College of General Practitioners
- Audiological Society of Australia
- Australasian Podiatry Council
- Australian Physiotherapy Association
- Australian Psychological Society
- Dieticians Association of Australia
- Optometrist Association Australia
- Pharmaceutical Society of Australia
- Speech Pathology Australia
- Australian Institute for Primary Care
- Primary Health Care Research and Information Service
- Council of Remote Area Nurses Australia
- Services for Rural and Remote Allied Health
- Department of Health and Ageing, Primary & Ambulatory Care Division
- Victorian Quality Council
- Australian Council on Healthcare Standards
- Quality Improvement Council
- Victorian Healthcare Association
- Australian Chronic Disease Prevention Alliance
- Australian Institute of Health and Welfare
- Centre for Allied Health Evidence South Australia
- Disability Services Division, Department of Health, Victoria
2 Expert Advisory Panel held in June 2011

The following organisations and committees were represented:

- Australian Institute of Health and Welfare
- Australian Commission on Safety and Quality in Health Care Primary Care Committee (3 members)
- Department of Health and Ageing, Primary & Ambulatory Care Division
- Victorian Healthcare Association
- Improvement Foundation
- The Royal Australian College of General Practitioners
- Australian Council on Healthcare Standards
- Council of Remote Area Nurses Australia
- Australian Association of Practice Managers
- Department of Health and Human Services, Tasmania
- Department of Health, Victoria

3 Consultation Paper

Submissions were received from the following organisations and individuals in response to the consultation paper released in September 2011.

- Doug Stevenson, Southern Fleurieu Health Service
- Philippa Cahill, Calvary Health Care, Sydney
- Michael Greco, CFEP Surveys
- West Moreton – Oxley Medicare Local Ltd and Brisbane South Division Limited
- Consumers Health Forum of Australia
- The Australian Clinical Psychology Association
- Services for Australian Rural and Remote Allied Health
- Alex McLaren, Wentwest
- John Stafford
- Medicare Local ACT
- CRANAplus
- Department of Health and Human Services, Tasmania
- Department of Health, Northern Territory
- The Royal Australian College of General Practitioners
- Department of Health, Victoria
Synthesis of submissions on the consultation paper and recommended national indicator set

- Statewide Service Strategy, SA Health
- Primary Care Network, Department of Health WA
- Dr Murray Thomas
- The Australian Psychological Society
- Dr Brian Maguire
- Health Quality and Complaints Commission
- Australian College of Rural and Remote Medicine
- Pharmaceutical Society of Australia
- Menzies School of Research
- Primary Health Care Research & Information Service
- Inner South Community Health Service
- National Medicines Policy Committee
- Melbourne East General Practice
- General Practice Network South
- Michelle Zimmerman
- Australian Dental Association
- Australian Institute for Primary Care & Ageing
- NSW Multicultural Health Managers Forum
- Australian Sonographers Association
- Australian General Practice Network
- Justice Health NSW
- Allied Health Professions SA
- SA Health
- National Heart Foundation of Australia
- Dietitians Association of Australia
- Royal College of Nursing Australia
- Australian Practice Nurses’ Association
- Victorian Healthcare Association
- Queensland Health
- NPS
- The Royal Australian College of Physicians
- NSW Health
- ACT Health