

**AUSTRALIAN COMMISSION
ON SAFETY AND QUALITY IN HEALTH CARE**

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**Patient safety and quality
improvement in primary care**

Consultation paper

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Summary

This consultation paper has been prepared as the first phase of a program of work to develop a national approach to support improvements in patient safety and quality in primary care. This paper provides an overview of the current patient safety and quality improvement environment in primary care. It describes the role of the Australian Commission on Safety and Quality in Health Care (the Commission) to lead and coordinate improvements in the safety and quality of care provided by Australian health services, and outlines planned improvement strategies to be undertaken by the Commission to support patient safety improvements in the primary care sector. The paper also seeks feedback from primary care sector stakeholders on what other national improvement strategies could be implemented.

For the majority of Australians primary care is the first point of contact within the health system, and provides a range of services for the prevention and management of acute and chronic conditions.¹ Australia's primary care sector consists of a myriad of public, private and non-government organisations; many of these have their own complex mix of funding arrangements, and many can best be described as small businesses in health.²

The current primary care system performs well and most health care is associated with good clinical outcomes. However, some people do not receive all the care that is recommended to them; there is considerable variation in access to and outcomes of health care across geographic areas, and preventable adverse events continue to occur across the Australian healthcare system.^{1, 3, 4}

There are a number of programs developed and implemented by governments, professional membership associations and a range of other stakeholder organisations in the primary care sector that aim to reduce risks to patients and improve the quality of care. However, these programs can be disparate, sometimes duplicative, and unevenly distributed, and are often not linked to long-term processes that ensure their sustainability. At present there is no nationally consistent or coordinated approach to driving patient safety and quality improvement in primary care.

Furthermore, to date there has been limited evaluation of the effectiveness of existing safety and quality strategies and programs implemented in Australian primary care settings. There is also limited evidence available internationally about effective and sustainable patient safety solutions in primary care. This has led to a global call for action on patient safety and quality improvement in primary care settings to better understand the nature and magnitude of adverse patient outcomes and how they can be addressed in these settings.⁵

The Commission's role is to lead and coordinate national improvements in the safety and quality of health care. The Commission works in partnership with the Australian Government, state and territory governments and the private and primary care sectors to achieve a safe and high-quality, sustainable health system. In doing so, the Commission also works closely with patients, carers, clinicians, managers, policymakers and healthcare organisations.⁶ The Commission's remit includes all areas of health care, including primary and acute care sectors as well as public and private health service organisations. The Commission, together with primary care partners and consumers, plans to develop a series of nationally consistent strategies, tools and resources to support improvements in the safety and quality of care provided by primary care services. A systems focus, which involves making changes at an organisational level within services and reorganising care delivery systems, will help support improvements in the quality of primary care and ensure it is sustainable, efficient and effective.⁷

There are many possible strategies to support patient safety and quality improvement in primary care. Some of these fall within the remit of the Commission, while others are the domain of professional bodies, quality improvement organisations and individuals. It is not intended that the work of this program, to develop a nationally consistent approach to patient safety and quality improvement in primary care, would replace existing safety and quality programs that are developed and maintained by professional groups and health departments, or which are required by legislation. It is anticipated that any outputs from this program would be developed in collaboration with primary care stakeholders to enhance and add value to existing programs; address identified patient safety and quality improvement gaps; work in areas that require a national focus, and not duplicate existing safety and quality initiatives.

The Commission has planned two improvement strategies to commence immediately. The first is the development of nationally consistent safety and quality health service standards for use by primary care services where a safety and quality framework does not currently exist. The second strategy involves a review of the Commission's practice-level indicators for primary care to support service improvement through performance monitoring and benchmarking. The Commission is seeking feedback from primary care stakeholders on these proposed strategies to support patient safety and quality improvement in primary care.

Primary care stakeholders may also identify additional strategies that could be implemented to support patient safety and quality improvement in the sector. The Commission is seeking feedback from primary care stakeholders about other patient safety and quality improvements strategies, tools or resources that may be implemented.

This consultation paper has been developed to assist stakeholders to provide feedback on patient safety and quality improvement strategies for primary care. Section 7 of this consultation paper outlines questions for primary care stakeholders and consumers to consider when providing feedback. These questions relate to:

- The scope of primary care services that may use and benefit from nationally consistent safety and quality strategies, tools and resources
- The safety and quality issues currently experienced in primary care services and how these are being addressed
- Future development and implementation of nationally consistent safety and quality health service standards and indicators for primary care services, including identifying any barriers and enablers, and organisations involved in or providing support to primary care services
- Other safety and quality strategies, tools and resources that could be developed to support primary care services and factors that might influence the development and implementation of these
- Consumer perceptions of safety and quality in primary care and the issues that are most important to them.

1. Introduction

Primary care is typically where individuals have their first contact with the health system. Primary health care covers health promotion, prevention, early intervention, treatment of acute conditions, management of chronic conditions and end-of-life care.⁸ Primary care is delivered by a diverse range of health practitioners, including Aboriginal and Torres Strait Islander health practitioners, allied health professionals, community and practice nurses, dentists, general practitioners, midwives, nurse practitioners and pharmacists.^{1,2} These services can be delivered in the home, general or other private practice, community health services and local or non-government services. Primary care services represent a significant proportion of all health care provided in Australia. In 2014–15, 335 million out-of-hospital services were claimed through Medicare.⁹

Primary care services are funded by multiple sources. This funding includes Australian Government programs such as Medicare, the Pharmaceutical Benefits Scheme (PBS), Aboriginal and Torres Strait Islander-specific services, Department of Veterans' Affairs home and health care programs, targeted health prevention and promotion programs, and other flexible funding arrangements that provide benefits to patients to access services.^{8,10} Primary care services may also be funded by state and territory government programs, including targeted primary and community health services, local government programs, non-government organisations, fees directly charged to patients or clients, private health and worker's compensation insurers, and other non-government funding from private charities focused on specific issues.⁸

Funding, regulatory and policy oversight for much of primary care in Australia is predominately the responsibility of the Australian Government. In April 2013, the Australian Government Department of Health released the *National Primary Health Care Strategic Framework*², which outlines an agreed approach for supporting and improving the Australian primary care system. State and territory governments are responsible for developing state-specific bilateral plans to implement the framework.

The framework focuses on four strategic outcomes:

1. Reorienting the primary care system to ensure it is consumer focused
2. Improving access and equity of primary care services
3. Increasing the focus on preventative care, screening and early intervention
4. Improving the quality and safety performance of primary care services.

There are a range of stakeholder organisations and professional associations and colleges that also have responsibilities for supporting and improving the Australian primary care system, and who partner with the Australian, state and territory governments and agencies to deliver improvements to the primary care sector.

Many primary care services can best be described as small businesses. Primary care services are frequently small; often have few dedicated resources available to support patient safety and quality improvement initiatives; and mostly rely on busy clinicians and clerical staff to implement improvement strategies in addition to their existing roles. In the primary care sector a patient may receive care from a number of different health professionals in separate locations over a period of time. Sometimes care may be planned or coordinated by a single provider, such as a general practitioner; however, in many cases it is un-referred and patient driven.

Although most health care in Australia is associated with good clinical outcomes, some people do not receive the care that is recommended to them or they are inadvertently harmed by the care they receive. Unsafe or ineffective primary care can increase mortality

and morbidity from preventable adverse events.¹¹ A well-functioning primary care sector improves the overall health of the population and reduces acute hospitalisations.¹²

The evidence about the nature or magnitude of patient harm in primary care settings is scarce but growing.⁵ To date, the majority of work on patient safety and quality improvement has focused on the acute hospital sector; however, a better understanding of the nature of harm to patients in primary care settings is important given that a significant proportion of care is provided in these settings.¹³

In all healthcare settings, the safety and quality of care an individual receives relies on the skills and performance of specific clinicians and available resources, as well as the effectiveness of the clinical governance and management processes of health service organisations. Health service organisations, including primary care services, have a responsibility to provide safe, high-quality care to patients.¹⁴ However, implementing safety systems and improvement strategies to achieve this can be challenging.¹⁵ Improvements in the care provided by primary care services will require changes at both the local level, within primary care services; and at a systems level, within the organisations and institutions that support primary care services.⁵

This paper has been developed to:

- Provide an overview of what is known about patient safety in primary care and describe some of the safety and quality initiatives currently in place for primary care
- Outline key drivers for change in primary care safety and quality
- Provide an overview of the national approach to safety and quality improvement in health care, the role of the Commission in supporting improvements in safety and quality in health care, and outline some of the strategies that the Commission has implemented to improve safety and quality in health care
- Describe safety and quality strategies that the Commission will be undertaking to build on existing strategies and improve safety and quality in primary care
- Seek feedback and information from primary care sector stakeholders on the proposed strategies and other safety and quality strategies that are needed or could be put in place.

Questions for primary care stakeholders and consumers are outlined in section 7 of this consultation paper.

2. Safety and quality in primary care: the current environment

This section describes the available evidence on patient safety risks and quality in primary care. The following sections provide an overview of some of the current initiatives seeking to address these risks and some of the key drivers for change.

Safety and quality risks in primary care

Little is known about the frequency, causes and consequences of errors and adverse events in the primary care sector because there is little available information that describes the safety and quality risks.^{16,17} A majority of the patient safety research in primary care is concentrated in general practice settings. The research on patient safety risks in general practice is more advanced and has shifted in recent years from describing the different types of patient safety risks to further investigating detection methods and links with patient safety culture.¹⁸ Research on the patient safety risks in other primary care settings, however, is at an earlier stage and focuses on developing an understanding of what the patient safety risks are for these services.

The information that does exist about patient safety incidents and risks in primary care has led to a global call for action to better understand the nature and magnitude of harm in the primary care sector.⁵ The evidence of preventable harm in primary care is growing. Recent research into the characteristics of patient safety incidents has been conducted in a range of primary services, including midwifery, home care services, dentistry, chiropractic and occupational therapy.¹⁸

Despite the lack of systematic research in this area, researchers have attempted to collate the available evidence to estimate the frequency of harm and understand the causes of patient harm in primary care. One review of published literature found that patient safety incidents in primary care, mostly general practice settings, occurred between 5 and 80 times per 100,000 consultations.¹⁹⁻²¹ Another review that looked at both published and unpublished literature on patient safety incidents in primary care over a 30-year period from 1980 found reports of between <1 and 24 patient safety incidents per 100 consultations.¹⁷ However, the study population again consisted mostly of patients treated within general practice settings.

When looking at the level of patient harm as a result of patient safety incidents in primary care, it is estimated that overall, harm is considered mild to moderate rather than severe.¹³ Approximately 4% of patient safety incidents in primary care result in patient harm that is severe, leading to a significant or long-term impact on a patient's physical or psychological well-being.¹⁷ Incidents that result in severe harm are related predominately to errors with prescribing and misdiagnosis or delayed diagnosis. In the UK, where they have a nationally mandated incident reporting system, data from reported incidents shows 2–3% of all primary care encounters, usually general practice services, result in a patient safety incident, and one in 25 of these incidents will cause serious harm to the patient.²²

The Threats to Australian Patient Safety (TAPS) Study was one of the first studies to estimate the incidence of errors in Australian primary care settings.²³ Researchers used an anonymous reporting system for general practitioners over a 12-month period to collect reports of errors in general practice settings. They found that for every 1,000 Medicare items billed by general practitioners, at least one error was reported, and two errors were reported for every 1,000 individual patients seen per year.²³ Analysis of over 400 errors found that

nearly 70% could be attributed to failures in systems or processes for care and only 30% related to human factors or the skills of practitioners.²⁴ The sample for this study was small and the results may not be generalisable beyond general practice settings. There are currently no reliable estimates about the frequency of patient safety incidents or preventable harm from other types of primary care services in Australia.

A systematic review of internationally published and unpublished studies conducted by the World Health Organization (WHO) in 2014 sought to identify the most common categories of patient safety incidents in primary care.¹⁷ These were:

- Administrative and communication incidents, including incomplete, unavailable or incorrect documentation, inappropriate monitoring of pathology testing and insufficient communication between practitioners or between practitioners and patients
- Diagnostic incidents including misdiagnosis or missed diagnoses
- Prescribing and medication management incidents including prescribing or dispensing incidents.

These categories are consistent with contributory factors identified by the WHO Safer Primary Care Expert Working Group at their inaugural meeting in 2012. The working group, which includes representation from Australia, identified six key factors as contributing to patient safety incidents.¹³ These include:

- Communication between healthcare professionals and patients
- Teamwork within the care team
- Laboratory and diagnostic imaging investigations
- Issues relating to data management
- Transitions between different levels of care
- Patient record completeness.

Analysis in the UK of reported patient safety incidents in primary care and general practice and the factors that contributed to these incidents further supports the findings from the WHO.²⁵ The combination of human factors and system weaknesses are commonly identified as contributing to patient safety incidents in primary care services rather than patient-related factors.²²

The interface between the acute sector and primary care services can also be problematic.²⁶ Delays in providing accurate and timely information on patient care and differences in processes such as handover create additional preventable risks for patients.²⁷ An analysis of patient safety incident reports relating to older people's care by primary care and general practice services in the UK found communication-related incidents accounted for 25% of all reports.²² It has been identified that a significant proportion of safety incidents that are captured by the acute sector may have originated in the primary care sector or were preceded by a communication-related incident prior to hospitalisation.^{13, 22} Yao et al estimated that one-third of adverse events could be prevented by implementing improved clinical handover practices.¹⁸

Improvements in care cannot be implemented until the level of harm and the reasons for it are better understood by service providers.²⁸ In primary care services, systems to identify and report patient safety incidents have been available since the mid-1990s; however, their use is limited, particularly in Australia.^{18, 29} Large volumes of clinical and non-clinical information are collected daily by primary care services but this information is rarely used to support improvements in service quality.²⁵

The use of incident reporting systems is more advanced in general practice settings, where the focus now is on improving processes to enhance reporting and learning lessons from

incidents. Standards for general practice accreditation in Australia require practices to implement clinical risk management systems to capture near misses and mistakes in clinical care.³⁰ The approach to these systems is varied and information about incidents and their analysis may not be shared beyond the practice.

The use of incident reporting systems in other primary care services is not well known and there is currently no national integrated incident reporting and learning system for all primary care services in Australia.¹⁸ The NHS National Reporting and Learning system in the UK is the only compulsory national incident reporting system that enables primary care services to record patient safety incidents at a local level, and for these to be analysed and shared to support improvements in patient safety within services and at a national level. Despite increasing calls to embed patient safety incident reporting in primary care services, a lack of clear governance, infrastructure and patient safety leadership has so far significantly limited the use of incident reporting by primary care services generally.³¹

Clinical governance is an integrated component of corporate governance of health service organisations. Clinical governance is the set of relationships and responsibilities established by a health service organisation or providers to ensure good clinical outcomes. It ensures that everyone – from members of governing bodies such as boards, frontline clinicians and managers – is accountable to patients and the community for assuring the delivery of safe, effective, and high-quality services. Clinical governance systems provide confidence to the community and the health service organisation that the systems are in place to deliver safe and high-quality health care. In primary care services, one or a small number of people may hold many of these organisational roles. Clinical governance in an organisation of any size supports the anticipation and mitigation of risks of harm for patients and consumers and establishes a learning environment focused on creating safe, effective and responsive services.³²

The need for a robust clinical governance framework for primary care services to support improvements in patient safety and quality of care in the sector has been identified in a number of reports and policy frameworks developed over the last decade.²⁴ However, the diversity and independence of primary care services, the lack of systematic communication and collaboration within and between primary care services, and varying management structures, have hindered attempts to establish a clinical governance framework for Australian primary care services.

The paucity of evidence on effective patient safety initiatives for primary care may contribute to a lack of awareness among primary care practitioners about risks to patient safety and create barriers to investment in strategies for improvement.^{29, 33} A number of safety and quality strategies, tools and resources to support improvements in primary care are slowly becoming available, particularly those developed by professional organisations and special interest groups.¹⁸ However, very few high-quality studies have examined their effectiveness in addressing patient safety risks in primary care. More rigorous evaluation is required to support improvements in the sector.

3. Registration and accreditation for primary care services

In recent years a number of professional associations and other stakeholders have worked to establish safety and quality initiatives to support primary care services. Primary care practitioners may be subject to multiple and overlapping registration and accreditation programs. The settings in which primary care practitioners work may also be subject to accreditation or formal review processes in addition to registration or accreditation of individual practitioners.

Registration commonly refers to processes that apply to individual practitioners to confirm they have the relevant education and training to provide healthcare services and creates an obligation to maintain their clinical skills and knowledge and abide by codes of conduct that are consistent with community expectations of health practitioners.

Accreditation commonly refers to processes of independent assessment and verification that standards have been implemented in settings, such as practices, clinics or services where care is provided. The process is the same irrespective of the number, mix or registration of the workforce. Accreditation seeks to ensure that the primary care service has systems and processes in place to support primary care practitioners to deliver safe, high-quality care.

The following sections provide a brief overview of some of the registration and accreditation programs that apply to healthcare practitioners and primary care services. This list is not exhaustive but provides examples of programs that exist. However, there are likely to be projects under way that are not documented.

The National Registration and Accreditation Scheme

In 2008, the Council of Australian Governments (COAG) agreed to establish a single national registration scheme for registered health practitioners.³⁴ On 1 July 2010, 10 health professions became regulated under the national scheme, with a further four professions joining them in 2012.³⁴ Paramedics are expected to join the national scheme in the second half of 2018 following agreement from health ministers in 2015.

The national scheme aims to support safety and quality of care by protecting practitioner titles without restricting competition or limiting access to care.³⁵ The national registration scheme has six objectives, which are to:

1. Protect public safety
2. Facilitate workforce mobility across states and territories
3. Facilitate high-quality education and training of health practitioners
4. Facilitate assessment of overseas-trained health practitioners
5. Promote access to health services
6. Develop a flexible, responsive and sustainable health workforce.^{34, 35}

The Australian Health Practitioner Registration Agency (AHPRA) was established to support implementation of the national registration scheme and provides support to the national boards of each profession in the scheme. The scheme requires each profession's national board to set registration standards, including codes of conduct and practice guidelines, that practitioners must meet.³⁴ Once registered, practitioners must continue to meet these standards and renew their registration annually.³⁴

An independent review of the national scheme was conducted in 2014–15. Following recommendations from this review report, the Australian Health Ministers' Advisory Council (AHMAC) commissioned an independent review of accreditation systems.³⁶ This review is focused on the costs of the accreditation functions and identifying opportunities for streamlining arrangements; the accreditation standards and their links with the development and delivery of education programs; and alignment of the national scheme with governance and reporting objectives.³⁶ The final report is expected to be released by the end of 2017.

National Code of Conduct for healthcare workers

Primary care practitioners who are outside the scope of the national registration scheme are required to comply with the National Code of Conduct for healthcare workers (the national code). The national code aims to protect the public by setting minimum standards of conduct and practice for all unregistered practitioners that provide healthcare services.³⁷ The national code sets standards against which disciplinary action can be taken, or prohibition orders issued, in the event a practitioner's actions present a serious risk to public health and safety.³⁷ Each state and territory has responsibility for progressing and monitoring implementation of the national code.

For some primary care practitioners, their profession may be self-regulated. The National Alliance of Self Regulating Health Professions (NASRHP) is an independent body that supports peak allied health professional bodies that fall outside the current scope of the national registration scheme.³⁸ The NASRHP provides benchmark standards for regulation and accreditation of practitioners of unregulated professions in line with national requirements outlined in the National Code of Conduct for healthcare workers.

National General Practice Accreditation Scheme

Accreditation of general practices has been in place since the late 1990s. General practice accreditation is a key entry criterion for access to the Practice Incentives Program (PIP) administered by the Australian Government Department of Health (the Department). The PIP is a flexible funding arrangement for accredited general practices that aims to support activities that encourage continual improvements in the delivery of quality care and ensure capacity, access and good health outcomes for patients.³⁹

In 2011, the Australian National Audit Office (ANAO) reviewed the Department's management of the PIP. It made three recommendations to support improvements to the management of the program. The third recommendation related to general practice accreditation, and recommended that the Department of Health better inform itself of the quality of general practice accreditation.⁴⁰

In June 2013, the Department engaged the Commission to undertake a project in collaboration with the Royal Australian College of General Practitioners (RACGP) to develop a governance and reporting framework for general practice accreditation to address Recommendation 3 of the ANAO's review of the PIP.

In May 2016, the Australian Government Minister for Health endorsed implementation of the National General Practice Accreditation Scheme. The scheme commenced on 1 January 2017 to support the consistent assessment of Australian general practices to the RACGP *Standards for general practices*. The scheme includes:

- An industry-based stakeholder committee to provide governance and oversight of the scheme

- An application and approval process for accrediting agencies assessing general practices
- A data collection and reporting framework for accrediting agencies that requires the submission of de-identified accreditation outcomes.⁴¹

Quality Care Pharmacy Program

The Quality Care Pharmacy Program (QCPP) is a quality assurance program for community pharmacies administered by the Pharmacy Guild of Australia. The QCPP supports effective pharmacy business operations and provides guidance on professional health services.⁴²

Accreditation of community pharmacies commenced in 1997 and more than 90% of Australian pharmacies are accredited.⁴² Pharmacies are externally assessed once every two years by QCPP licensed assessors. In 2011, the Pharmacy Guild of Australia was accredited by Standards Australia as a Standards Development Organisation and QCPP recognised as an Australian Standard.

Australian Psychological Society Professional Practice Management Standards

The Australian Psychological Society developed the Professional Practice Management Standards to support psychologists in private practice to implement processes for good practice and instil public and government confidence in the profession.⁴³ The 16 standards cover six areas, including: service provision; rights, responsibilities and safety; client information management; continuing education and quality improvement; business and human resource management; and the environment of the practice. Psychologists implement the standards and participate in a self-assessment exercise, which provides feedback on their performance and identifies opportunities for improvement, as well as contributing to their ongoing continuing professional development requirements.⁴³

Physiotherapy Association Australia Accreditation

In 2007, the Australian Physiotherapy Association (APA) developed the *APA Standards for Physiotherapy Practices*.⁴⁴ The standards are designed to support safe, high-quality care and continuous quality improvement in physiotherapy practices.⁴⁴ Physiotherapy practices can use the standards to self-assess their safety and quality performance, or undergo accreditation through an external assessment via a desktop audit, or an onsite assessment.

Safety and quality guidelines for midwives

The new *Safety and quality guidelines for privately practising midwives* were published in February 2016 and came into effect on 1 January 2017.⁵¹ The guidelines were developed by the Nursing and Midwifery Board of Australia (NMBA), which regulates the practice of nursing and midwifery in Australia, and they replace the *Safety and quality framework for privately practising midwives providing homebirth 2011*.^{51, 52} The guidelines apply to privately practising midwives, including those that provide home birth services. They have been developed in the interest of public safety and to provide clarity and support to privately practising midwives to practise safely.⁵² The guidelines address the following areas⁵²:

- Informed consent, which must be obtained by all women in their care according to relevant guidelines and legislation
- Risk assessment, including a documented process for identification and evaluation of clinical risk and evidence of risk mitigation strategies to address these

- Referral pathways, which should be clearly articulated and documented in line with national midwifery guidelines
- Collaborative arrangements, in accordance with national guidance on collaborative maternity care
- Submission of reports and data, including contributions to all required national, state and territory perinatal data collections
- Clinical audit, to enable data collections in accordance with national core maternity indicators as well as peer and reflective practice
- Adverse event management, including notifying and reporting incidents and adverse events, or more serious categories of sentinel events in accordance with relevant national, state or territory health department requirements
- Professional practice review, which includes annual and regular continuing professional development.

Other elements of the guidelines include registration standards, professional codes, guidelines and legislative requirements that are required for all midwives to practise in Australia.⁵² Privately practising midwives must participate in an audit against the guidelines on a three-yearly basis or more frequently, as determined by the Nursing and Midwifery Board of Australia.

The Australian College of Midwives is developing an accreditation program to support privately practising midwives to comply with the guidelines. The accreditation program MidSURE is based on the Midwifery Practice Scheme funded by Queensland Health in 2015–16 and aims to support safe, high-quality midwifery practice by providing access to resources, tools and education. Additional elements, such as clinical incident monitoring and clinical governance functions, are outside the scope of the initial implementation of MidSURE but may be considered in the future depending on the developing regulatory requirements. The MidSURE program will be released in the coming years.

Home Care Common Standards

The Home Care Common Standards, formerly known as the Community Care Common Standards, are applicable to service providers as part of the Home and Community Care (HACC) Program, Commonwealth-funded packaged care programs and the National Respite Carers Program (NRCP).⁴⁵

The standards are developed and managed by the Australian Aged Care Quality Agency.

The quality review process assesses whether:

- Services are safe and high quality
- Services meet the identified needs of service users
- Consumer expectations for service delivery are being met
- Funds are being used according to their specified purpose.⁴⁵

The quality review process is conducted once every three years and includes onsite assessment, outcome reporting and improvement planning components.

Safety and quality in the hearing services sector

Since late 2015, hearing service stakeholders – including consumer groups, professional bodies, industry representatives and the Australian Government Office for Hearing Services – have been working towards the development and implementation a safety and quality

framework for hearing care services.⁴⁶ To date there has been significant progress made by hearing services professional bodies to develop a unified set of documents that address professional practice standards, code of conduct and scope of practice for hearing care practitioners.^{47, 48} Options are currently being considered as to whether the NSQHS Standards developed by the Commission could be applied and, if needed, adapted for use in hearing services as part of the hearing services framework.

Continuous Quality Improvement for Aboriginal Community Controlled Health Services

Over the last decade, Australian Government and state and territory governments have been providing increasing levels of support for Aboriginal Community Controlled Health Service Organisations (ACCHOs) to implement strategies that aim to improve the efficiency and effectiveness of primary health care for Aboriginal and Torres Strait Islander people.⁴⁹

In 2015, the Australian Government Department of Health commissioned the Lowitja Institute to work in partnership with key stakeholder organisations to develop the *National CQI Framework for Aboriginal and Torres Strait Islander Primary Health Care 2015–2025* (the National CQI Framework).⁵⁰ The purpose of the National CQI Framework is to foster commitment to, and support of, a coordinated approach to continuous quality improvement in primary care services that provide care to Aboriginal and Torres Strait Islander people. The National CQI Framework identifies the core components necessary to embed continuous quality improvement in everyday practice at the local level as well as requirements for implementation support at local, regional, state and territory and national levels.⁵⁰

The National CQI Framework is still under development and is subject to ongoing consultation with the Aboriginal and Torres Strait Islander health sector.

Other quality improvement initiatives in operation in ACCHOs include:

- Continuous quality improvement models, such as One21seventy and the Australian Primary Care Collaboratives program
- Funding programs, such as the Healthy for Life program, Closing the Gap and Indigenous Chronic Care Package
- Audit tools, such as the PEN Computer Systems' Clinical Audit Tool and the Aboriginal Health Promotion and Chronic Care Partnership tool
- Accreditation programs, including the RACGP *Standards for general practices* and Accreditation for Remote Services.⁴⁹

4. Drivers for change

Some of the existing policy reforms within the primary care sector aimed at improving care and outcomes are outlined in this section.

Better Outcomes for People with Chronic and Complex Health Conditions

In 2015, the Australian Government established the Primary Health Care Advisory Group to consider opportunities for reform of the primary care sector to better address the needs of patients with chronic and complex conditions.⁵³ The Primary Health Care Advisory Group released a report in December 2015.

The report details the evidence for change and recommends broad adoption of a new model of care and supporting reforms to better meet the needs of Australians with chronic and complex conditions into the future. Central to the proposed reform is the formalisation of the relationship between a patient with chronic and complex conditions and their Health Care Home: a setting where they can receive enhanced access to holistic coordinated care, and wrap-around support for multiple health needs. A Health Care Home may be a general practice or an Aboriginal Community Controlled Health Service (ACCHS).⁵⁴

By 31 December 2017, 200 general practices and ACCHSs across 10 regions in Australia will have commenced delivery of Health Care Home services as part of the Stage 1 trial of the new reforms. The Health Care Homes will be responsible for developing a shared care plan with eligible patients and coordinating their care across primary and acute care services as required.⁵⁴ Health Care Homes will be funded to perform these care coordination functions through bundled monthly payments for each patient that are linked to the complexity of their healthcare needs.⁵⁵

National Disability Insurance Scheme

The National Disability Insurance Scheme (NDIS) is being progressively rolled out from 1 July 2016.⁵⁶ The National Disability Insurance Agency (NDIA) has been established to oversee its implementation and manage the scheme. The NDIS will change the way care and services are provided to people under 65 who have a permanent and significant disability. Central to the reforms is the development of individualised NDIS plans that identify consumers' goals of care and the services to be accessed to achieve these goals.

Providers of disability support services are now required to register and meet specific suitability criteria.⁵⁶ Registered providers will also need to comply with the requirements of the Quality and Safeguards Framework. The NDIA has developed the Quality and Safeguards Framework with input from state and territory governments, to ensure there is a national approach to providing safe, high-quality services. The Quality and Safeguards Framework will be effective once the roll-out of the NDIS is completed in full.

Primary Health Networks

In July 2015, the Australian Government established 31 Primary Health Networks (PHNs), building on the structures, operations and functions of Medicare Locals. PHNs have two key objectives: to increase the efficiency and effectiveness of medical services for patients, and to improve coordination of care.⁵⁷ Each PHN is required to work with their local health or hospital network, general practitioners, allied health and other primary care practitioners in

their local area to identify local population needs and service gaps. This will inform PHN planning, implementation and evaluation of innovative models of care to improve local health outcomes. One of the key roles of PHNs is to provide practice support services to general practices, including supporting general practices attaining the highest standards in safety and quality. They are also tasked with commissioning services to address local patient needs, where they have opportunities to embed requirements around safety and quality into contractual arrangements.

Redesign of the Practice Incentives Program

The PIP has been a key driver of quality care in the general practice sector over the last two decades. As announced in the 2017–18 Federal Budget measure *Quality Improvement in General Practice*, a new PIP Quality Improvement Incentive will soon be available to general practice. Changes to the PIP have been co-designed in consultation with the PIP Advisory Group and extensive consultation with the sector in late 2016, which indicated broad support for the introduction of a new incentive focused on quality improvement. The PIP Quality Improvement Incentive will support general practices to better understand and improve their quality of care through participation in continuous quality improvement activities, and to achieve better outcomes for their patients.

National Digital Health Strategy

Over the last decade, Australian, state and territory governments have worked with the private and not-for-profit sectors to develop infrastructure to support a nationally coordinated digital health system. The Australian Digital Health Agency was established in July 2016 to support improvements in health outcomes for Australian patients through the delivery of the national digital health strategy and digital healthcare systems.⁵⁹ The new agency builds on the work of the former National E-Health Transition Authority and the Personally Controlled Electronic Health Record (now called My Health Record), and is working to address early implementation issues and review the strategy and role of shared electronic health records.⁶⁰

In August 2017 the COAG approved the *National Digital Health Strategy 2018–2022*.⁶¹ The strategy proposes seven strategic priority outcomes to be achieved by 2022. These are:

1. Health information is available as required by healthcare providers and consumers
2. Health information can be exchanged and communicated securely between healthcare providers and consumers
3. Standards to ensure consistent collection and sharing of high-quality data are available and applied to data collections
4. Information about medicines and prescriptions is available and accessible to healthcare providers and consumers
5. Digital health technology is available to support innovative models of health care, such as the Health Care Homes trial
6. Healthcare providers are trained and proficient in the use of digital health technologies to maximise its use and benefit for consumers
7. Development of digital health tools, apps and services are supported and expanded.⁶¹

Some sections of the primary care sector have made significant progress and investment in digital health and the use of technology to deliver services. Digital health refers to more than the establishment of the My Health Record system and the Healthcare Identifiers Service; it also includes development of national standards and specifications for the implementation and use of digital technologies in health care.⁶² The roll-out of digital health technologies across the health system provides opportunities to embed safety and quality principles in the

design of electronic systems. Quality improvement strategies within primary care services will be better supported through increased access to data and information.

Unwarranted healthcare variation

Variation in health care refers to the different patterns of healthcare use by different populations across geographic areas. Some variation in health care may be warranted and even desirable, based on the differing needs of populations or patient preferences. However, evidence suggests a significant amount of variation is unwarranted. In this type of variation people may receive care that is inappropriate or unnecessary, or they may miss out on care that would be beneficial.⁶³ Unwarranted variation may reflect differences in clinicians' practices, the organisation of health care or people's access to care. It may also reflect the provision of poor-quality care that does not follow best-practice guidelines.

In 2015, the Commission released the first *Australian Atlas of Healthcare Variation*.⁶³ The first Atlas used data from the Medicare Benefits Schedule, Pharmaceutical Benefits Scheme and Admitted Patient Care National Minimum Data Set to explore the variation in health care across different healthcare settings and geographic locations in six specific clinical areas⁶³:

1. Antimicrobial prescribing
2. Diagnostic interventions
3. Surgical interventions
4. Interventions for mental health and psychotropic medicines
5. Opioid medicines
6. Interventions for chronic disease.

A number of recommendations were made with the aim of reducing unwarranted variation. Some of these recommendations relate to changing the way primary care is organised, delivered and monitored, such as:

- Implementing antimicrobial stewardship programs in general practice and monitoring rates of antimicrobial prescribing by regional health networks
- Improving access to, and compliance with, relevant clinical guidelines for common diagnostic and surgical interventions
- Improving health practitioner access to, and knowledge of, clinical prescribing guidelines for antipsychotic medicines
- Addressing barriers to non-pharmacological treatments for sufferers of chronic pain and ensuring health practitioners have access to up-to-date prescribing guidelines for opioid medicines
- Implementing local collaborative, integrative screening and risk-assessment programs for chronic disease including asthma and diabetes.⁶³

In June 2017, the Commission released the *Second Australian Atlas of Healthcare Variation*.⁶⁴ The second Atlas includes interventions not covered in the first Atlas, such as hospitalisations for chronic diseases and caesarean section in younger women, as well as building on the findings from the first Atlas and further examining issues relating to hysterectomy and cataract surgery.

The second Atlas focuses on the following clinical areas:

1. Potentially preventable hospitalisations from chronic disease and infection
2. Cardiovascular conditions
3. Women's health and maternity
4. Surgical interventions.

Again, a number of recommendations were made in the second Atlas that relate to primary care. These include:

- Implementation of chronic disease management programs such as those described by the Primary Health Care Advisory Group¹ and the National Strategic Framework for Chronic Conditions⁶⁵
- The development of a clinical care standard on the management of atrial fibrillation
- In collaboration with medical and midwifery professional colleges, the development and dissemination of an agreed model of care for second-stage labour to minimise the risk of severe perineal trauma
- Development of an Australian guideline for the management of low back pain and sciatica
- Promotion of routine measurement and recording of obesity markers for all adults and children who attend primary care services.

Private health insurance funds

Private health insurance and the services it procures are of significant value to the Australian health system. In 2015, an estimated 47% of Australians held a private health insurance policy covering hospital treatment, while 56% held a policy covering general treatment.^{66,67} Overall, approximately 11% of all health services are paid for by private health insurers.⁶⁷ Insurers provide rebates to selected practitioners and health services, including primary care practitioners, for payment of fees for care or products provided to privately insured patients where there is no Medicare benefit payable.^{67, 68}

In recent years, insurers have started to use these agreements to promote improvements in safety and quality of care by introducing conditions that reduce or withhold payments to practitioners if the care provided does not meet certain standards or results in unexpected health outcomes.^{68, 69} Insurers have been driven by a need to ensure care provided represents value for money, and that care is clinically appropriate and in line with best practice.⁶⁸ Private health insurers include safety and quality components in their agreements with some primary care services. There is potential for insurers to include a broader range of safety and quality requirements in these agreements in the future.

Consumer expectations

Healthcare consumers no longer accept passive exchanges of information when accessing health care.⁷⁰ Increased access to information from digital and social media has changed consumer health behaviours and led to an increase in consumers' expectations of care.^{70, 71} More than ever, consumers are now exercising their right to make decisions about their care, and are seeking greater participation in planning their care as well as better value for money. Transparency of information about the performance of health services, such as the widely publicised failures of care delivered in public hospitals, has increased consumer scrutiny of safety and quality of health services.⁷²

The lack of an overarching policy framework to support consumer-centred care has been identified as one of the contributing factors to gaps in the quality of consumer engagement.⁷¹ There is a growing body of evidence that shows consumer-centred approaches to care can improve health care services' safety, quality and cost effectiveness, as well as consumer satisfaction.⁷³⁻⁸¹ The inclusion of partnering with consumers as one of the NSQHS Standards provides a framework for improved consumer engagement in acute health services. This framework could be adopted by primary care services to support greater numbers of primary care providers to work more closely with consumers.

5. National leadership for safety and quality improvement in health care

The Commission is a government agency that provides national leadership and coordination of strategies to improve the safety and quality of health care provided by Australian health services. This section provides an overview of the Commission's role and a few of the Commission's flagship programs, as well as outlining recent work with the primary care sector.

The Australian Commission on Safety and Quality in Health Care

In 2006, Australian, state and territory governments established the Commission to lead and coordinate national improvements in safety and quality in health care. In 2011, the Commission was established as a permanent entity under the *National Health Reform Act 2011*.

Section 9 of the Act sets out the Commission's functions, which include:

- Promote, support and encourage the implementation of strategies related to the safety and quality of health care
- Collect, analyse, interpret and publish information about the safety and quality of health care
- Formulate standards, guidelines and indicators relating to the safety and quality of health care
- Promote, support and encourage the implementation of standards, guidelines and indicators to improve the safety and quality of health care
- Formulate, implement and manage model national accreditation schemes for health service organisations
- Consult, co-operate and advise Health Ministers, state and territory governments and other stakeholders on the safety and quality of health care.⁸²

The vision of the Commission is to ensure and promote safety and quality of care for every person, everywhere and every time. The Commission aims to use its role as the national body for safety and quality in health care in Australia to ensure that the health system is better informed, supported and organised to deliver safe and high-quality care. The Commission works in partnership with the Australian Government, state and territory governments and the private and primary care sectors to achieve these aims.

The Commission's work focuses on four strategic priority areas:

1. Patient safety
2. Partnering with patients, consumers and communities
3. Quality, cost and value
4. Supporting healthcare practitioners to provide safe and high-quality care.

The Commission's Board is appointed by the Australian Government Minister for Health, in consultation with state and territory health ministers. Appointments to the Commission Board are based on members' experiences and knowledge in the fields of healthcare

administration, health service provision, primary health care, law and management, consumer advocacy, corporate governance and safety and quality.

The Board is supported by a number of specialised sub-committees including the:

- **Inter-Jurisdictional Committee**
Which is made up of senior safety and quality managers from the Australian, state and territory government health departments, and which is responsible for providing advice on the process of policy development and facilitating jurisdictional engagement in the Commission's work
- **Private Hospital Sector Committee**
Which includes representatives from the private hospital and day procedure service sector, and which is responsible for liaising with the Commission on key safety and quality issues affecting the private hospital sector, and for providing input, feedback and assistance on the development and implementation of the Commission's safety and quality strategies
- **Primary Care Committee**
Which includes representatives from the primary care sector, and which is responsible for informing the Commission about key safety and quality issues affecting the primary care sector's performance, and for assisting with tailoring safety and quality strategies to enable their uptake in the primary care sector.

The Commission uses a collaborative and consultative approach to determine national priority areas for safety and quality in health care. Two of the Commission's foundation safety and quality programs are outlined in the following sections.

Australian Safety and Quality Framework for Health Care

The Commission developed the *Australian Safety and Quality Framework for Health Care* in 2009. The Framework aims to promote a common understanding of the nature of safety and quality in health care, and to define the strategic direction for safety and quality improvement in the Australian health system. It was endorsed by health ministers in 2010 and describes a vision for safe and high quality care for all Australians. The Framework specifies three core principles for safe and high quality care. These principles are that care is:

1. Consumer-centred
2. Driven by information
3. Organised for safety.

The Framework was developed to apply across the whole health system, including primary care. The Framework outlines 21 areas for action that are applicable across the health system. The actions can be adapted for use in different healthcare settings to improve the safety and quality of care. These actions cover:

- Providing care that is easy for patients and consumers to access when they need it
- Ensuring that health professionals respect and respond to the choices, needs and values of patients and consumers
- Forming partnerships between patients, consumers, family members, carers and health professionals
- Using up-to-date knowledge and evidence to guide decisions about care
- Collecting and analysing safety and quality data, and using this information for improvement
- Taking action to improve the experience of patients and consumers
- Making safety and quality a central feature of how health service organisations are run, how health professionals work, and how funding is organised.

The actions within the Framework align well with the priorities and objectives in the *National Primary Health Care Strategic Framework*.² Although the principles and areas of action in the Framework apply in primary care, the heterogeneous nature of the sector and different service delivery environments of primary care services would need to be considered when determining what types of strategies are likely to be most effective in improving safety and quality, and deciding how these should be implemented. Safety and quality strategies that are driven by changes in legislation and regulation, or that apply in the same way across all primary care services, may not be appropriate or possible given the diversity of the sector. A more effective approach may be to link proposed strategies for safety and quality improvement with existing programs, policies and organisations so that they become embedded in the systems that support and enable primary care in Australia. This is the basis of the two strategies that have been identified for action by the Commission, and which are described in section six of this paper.

The National Safety and Quality Health Service Standards

The NSQHS Standards were developed in consultation and collaboration with the states and territories, private hospitals, private sector organisations, technical experts and a wide range of stakeholders, including health practitioners and patients. The primary aim of the NSQHS Standards is to protect the public from harm and to improve the quality of care provided by Australian health services. They were endorsed by health ministers in 2011 and are mandatory for implementation in all Australian hospitals and day procedure services. The NSQHS Standards provide a nationally consistent statement about the level of care consumers can expect from health service organisations. They provide the basis for assessment of health service organisations to verify their implementation.

The NSQHS Standards provide a framework for improving the safety and quality of care that health services provide. They require the implementation of an organisational clinical governance framework and clinical risk mitigation strategies for high-prevalence adverse events, healthcare-associated infections, medication safety, patient identification and procedure matching, clinical handover, pressure injuries, acute clinical deterioration and falls. They also require a quality improvement program be implemented to support innovation and greater efficiency by health service organisations.

A review of the implementation of the NSQHS Standards in 2015 found that they have had a positive impact on the health system, including providing a focused framework for safety and quality activities and improving collaboration at different levels and across multiple health services. The time required to implement and monitor the NSQHS Standards was identified as a negative impact.

In 2015–16 the Commission reviewed and amended the NSQHS Standards. The second edition of the NSQHS Standards comprises eight standards:

1. Clinical Governance
2. Partnering with Consumers
3. Preventing and Controlling Healthcare-Associated Infection
4. Medication Safety
5. Comprehensive Care
6. Communicating for Safety
7. Blood Management
8. Recognising and Responding to Acute Deterioration.

The second edition also covers issues not covered by the first edition, including mental health and cognitive impairment, health literacy, end-of-life care and Aboriginal and Torres Strait Islander health. These areas were identified by the health sector as safety and quality gaps that should be addressed in the NSQHS Standards.

The NSQHS Standards (2nd edition) have been endorsed by health ministers and will be launched in November 2017. A copy of the latest NSQHS Standards (2nd ed.) is available from the [Commission's website](#). Implementation of and assessment to the NSQHS Standards (2nd ed.) will commence from 1 January 2019.

The Commission and the primary care sector

The Commission has been working to support patient safety and quality improvement in primary care for a number of years. A summary of key pieces of work the Commission has conducted in relation to primary care is provided in this section.

Public consultation on patient safety in primary care

In 2010, the Commission conducted a public consultation of primary care stakeholders about safety and quality in the sector. The Commission released *Patient Safety in Primary Health Care: A discussion paper*³³ to raise awareness of safety and quality issues in the primary care sector; to stimulate discussion about these issues; and to support coordinated national action to address them. A report describing feedback received during the consultation period was released in 2011.³³

Feedback from stakeholders identified a range of barriers to implementing safety and quality improvement strategies, including that there was a large amount of confusion between the different roles, expectations, qualifications and levels of professional development and support available to primary care practitioners.³³ In the consultation, stakeholders consistently identified system-level issues that contributed to patient safety risks. These included issues regarding access to primary care services, such as the availability of services, funding arrangements and the disincentive of increasing co-payments; and issues regarding the integration and coordination of care, such as referrals and transitions between care sectors.³³

Other issues that were raised by stakeholders during the consultation included the lack of systematic and coordinated collection of information about incidents of patient harm in primary care, the need for improved knowledge and understanding of the patient safety risks in primary care, improved communication between care providers and with consumers, improved consumer education, and increased access to consistent guidelines and standards for clinical care, risk management, governance and incident management.³³

Literature reviews

To better understand patient safety in primary care, the Commission contracted two literature reviews in 2009 and in 2015. Both reviews focused on the evidence of patient safety risks and incidents in primary care in Australia and internationally^{11,18} and evidence of effective risk-minimisation strategies in this sector.^{14,15} The reviews found very little information about patient safety risks, rate of incidents in primary care, or risk minimisation strategies.^{11,18} Where studies did exist, they were usually limited to general practice settings and their results were not generalisable across all primary care settings.

Shared decision making

The Commission has established a program of work focused on shared decision making and the development of resources and tools to support patient-centred care. Shared decision making refers to the integration of a patient's values, goals and concerns with the best available evidence about the benefits, risks and uncertainties of proposed treatment to support appropriate healthcare decisions.⁸⁴

The Commission has produced three patient decision aids, and plans to develop others, to support health services and practitioners engage with patients as partners in their own care. Patient decision aids help patients and practitioners by providing high-quality, synthesised information about specific conditions to enable comparison of the risks and benefits of treatment options according to the patient's values and goals for treatment.⁸⁵ The patient decision aids developed by the Commission relate to antibiotic use for sore throat, acute bronchitis and middle-ear infection in children in primary care. Work is under way to develop new decision-support tools in the areas of osteoarthritis of the knee and heavy menstrual bleeding.

The Commission has worked in collaboration with the RACGP on the production of an online module for doctors on risk communication. The module is available to RACGP members as part of their continuing professional development program. Adapted versions of the online module are now also available for use by other specialist colleges.

Clinical care standards

In 2013 the Commission established the Clinical Care Standards program to support clinical experts and consumers to develop standards on health conditions that would benefit from a nationally coordinated approach to reduce unwarranted variation and ensure delivery of appropriate care regardless of where a patient may be treated. This body of work has been identified as a priority area under the Commission's work plan.

A clinical care standard consists of a small number of quality statements that describe the care patients should be offered by practitioners and health services for a specific clinical condition or defined clinical pathway in line with current best evidence.⁸⁶ Each clinical care standard is developed with input from a topic working group made up of practitioners, researchers and consumers, and includes a public consultation process. Accompanying each clinical care standard is a series of suggested indicators to help health services monitor how well they implement the care described in the clinical care standard.

The Commission has developed seven clinical care standards since 2013, some of which are applicable to primary care. These are:

1. Antimicrobial stewardship
2. Acute coronary syndrome
3. Acute stroke
4. Delirium
5. Hip fracture care
6. Osteoarthritis of the knee
7. Heavy menstrual bleeding.

The Commission is also working on a clinical care standard focusing on venous thromboembolism prevention, which will be released in 2018.

The clinical care standards have been developed for use in a variety of healthcare settings, including hospitals, primary care services and aged care homes. Some clinical care standards may be more relevant to primary care than others. For example, antimicrobial stewardship and osteoarthritis of the knee have greater relevance to primary care services because of the central role primary care practitioners play in providing and coordinating care for patients with these conditions.

Progress of assessment of primary care services to the National Safety and Quality Health Service (NSQHS) Standards

Since 2013 the NSQHS Standards have been implemented voluntarily in some primary care settings by private dental practices and a number of community, ambulatory care, pharmacy and transport services. The Commission has worked with organisations such as the Royal Flying Doctor Service, the Australian Dental Association and a wide variety of community health services to support primary care services to interpret and adapt the NSQHS Standards for use in their local contexts. The Commission released the *NSQHS Standards Guide for Dental Practices and Services*⁸⁷ in 2015 and the *Guide to the NSQHS Standards for community health services*⁸⁸ in 2016 to support primary care services implementing the NSQHS Standards.

At 31 July 2017, 443 community health services had been assessed to the NSQHS Standards and received accreditation. During the same period approximately 1,800 private dental practices had been assessed to the NSQHS Standards.

6. Strategies to support patient safety and quality improvement in primary care

Patient health outcomes are improved when comprehensive, well-coordinated and patient-focused primary care systems are in place.^{1,89} A growing body of research has shown that while the Australian primary care system functions well, considerable improvements can still be made.¹ Improvement options that have been proposed include re-designing primary care systems to make them more patient-centred, easily accessible and coordinated.^{2, 45} There are challenges to implementing nationally consistent safety and quality improvement initiatives in primary care, including: the heterogeneous nature of the sector; limited data availability on the effectiveness of safety and quality initiatives; and the existence of few clear implementation mechanisms.

Studies have shown that changes to practice and systems are more significant and effective when multiple improvement strategies are implemented together, compared to the implementation of a single strategy.⁹⁰ System-level interventions focused on reducing human-related factors that contribute to harm are likely to produce the greatest improvement of the safety and quality of care provided by primary care services.²² To ensure that strategies to improve patient safety in primary care are coordinated and sustainable, they need to be embedded in the systems and infrastructure for primary care services, as well as in wider government and non-government programs, policies and funding arrangements. Research shows that a focus on systems helps support the effective implementation of both large and small-scale change in health care.⁹¹⁻⁹⁵

There have been a number of performance frameworks, safety and quality frameworks and strategies proposed for primary care to support different aims.^{96,97} However, there has been no agreement on the development, implementation or application of a single framework or approach to support patient safety and quality improvement in primary care. There is value in having a nationally consistent approach to patient safety and quality improvement across all sectors of the health system.^{22, 98}

Safety and quality frameworks are tools that enable systematic examination and evaluation of safety initiatives and which stimulate thinking about integrated quality improvement strategies. Some of the strategies that could support patient safety and quality improvement in primary care sit within the remit of the Commission. This section describes two specific strategies that the Commission plans to implement to improve safety and quality in primary care. Other strategies identified from the literature on primary care have also been outlined in this section and feedback from stakeholders is being sought on these strategies.

National Safety and Quality Health Service (NSQHS) Standards for primary care

The first strategy to be implemented by the Commission is the development of a set of NSQHS Standards for primary care services.

While the NSQHS Standards were developed for use by all Australian healthcare services, an increasing number of primary care services have been implementing them to support improvements in the safety and quality of care they provide. Some of these primary care services have provided feedback to the Commission that implementation of the NSQHS Standards has been challenging. This has been attributed, in part, to the differences in the language of the NSQHS Standards and how they apply to smaller, office-based settings, and to the information, communication and administrative systems used in primary care, compared with hospital-based settings.⁹⁹ These differences mean that additional support has been needed for primary care services to effectively implement the NSQHS Standards.

To address this issue, the Commission developed context-specific implementation guides for both dental and community health services.^{87, 88} Implementation support for primary care services has also been provided by some primary care professional membership organisations and colleges. However, with the growth in the number of primary care services implementing the NSQHS Standards and the variations in the services they provide, the need for implementation support will also increase.

A public consultation process on the draft NSQHS Standards (2nd ed.) conducted in August 2015 included primary care stakeholders. Feedback from these stakeholders supported the continued use of the NSQHS Standards in primary care services. However, respondents also stated that the NSQHS Standards needed to be amended to make them more applicable to primary care services and to ensure they addressed relevant safety and quality issues that are unique to the sector.

In line with this feedback, the Commission is planning to develop NSQHS Standards specifically for use in primary care services that do not have access to existing sets of appropriate standards or formal accreditation programs, and which may wish to adopt the NSQHS Standards to guide patient safety and quality improvement within their service.

Why do this work?

While a number of primary care services have implemented profession- or industry-based standards and accreditation programs, they are not always widely used or equally available across the primary care sector.

There are several issues associated with this disparate approach, including that:

- Not all primary care services or practitioners have access to standards or an accreditation program that adequately addresses their needs or the risks associated with the care they provide
- Some primary care services, such as Aboriginal Community Controlled Health Services, are assessed against multiple sets of standards, which is inefficient, costly and burdensome
- The standards for many primary care services do not always address governance, safety and quality improvement systems despite these being the goals of many programs.¹⁰⁰

Furthermore, challenges exist when trying to harmonise safety and quality systems across the care continuum. A patient's journey through the health system often crosses organisational boundaries and different standards apply in different services and jurisdictions.^{99, 101}

It is not intended that the NSQHS Standards for primary care services replace or duplicate existing sets of standards or accreditation programs that are used by specific professional groups, such as the RACGP's *Standards for general practices*. However, for those primary

care services or practitioners where safety and quality standards currently do not exist or where access is limited, the NSQHS Standards for primary care services would provide a framework to assist with the implementation of quality improvement activities. The Commission has been asked by stakeholders in the primary care sector, through feedback from multiple consultations and via members of the Primary Care Committee, to undertake this work.

The range of primary care services to which the NSQHS Standards for primary care services would apply has not yet been determined. For the acute sector, implementation of the NSQHS Standards is mandated by state and territory health ministers. For primary care services, however, requirements to implement standards for accreditation would depend on the governance and funding arrangements for individual primary care services. The Commission is not a regulatory body and therefore cannot mandate implementation of the standards by any primary care service. Instead, the Commission would work with relevant primary care stakeholders, such as professional associations, colleges and Primary Health Networks to support implementation of the standards by primary care services where required and where appropriate.

The development of standards alone, however, is not sufficient to support improvements, and there needs to be a mechanism for implementation and a process for verification. Arrangements would also need to be agreed with primary care stakeholders to manage situations where existing or multiple compliance regimes may apply to specific primary care services.

A set of nationally consistent safety and quality standards, such as the NSQHS Standards for primary care services, that harmonises with multiple sets of professional standards and is applicable to a wide range of primary care services, would help decrease the burden on services participating in multiple accreditation processes. It would also meet national requirements across a range of government programs, and support coordination of care between primary care services and Local Health Networks.

National safety and quality indicators for primary care

The second strategy will be a review of the practice-level safety and quality indicators for primary care that were first released by the Commission in 2012. This review will consider updating the existing indicators with a view to developing, in partnership with primary care services, systems to support improvement through performance monitoring and benchmarking.

The *National Health Reform Act 2011* that established the Commission outlines requirements for the Commission to develop indicators and recommend national datasets to support safety and quality in health care. The Commission's existing national indicators program aims to support safety and quality improvement in health care services by improving systems and processes for the collection, use and reporting of safety and quality information.¹⁰²

To date, the Commission's work on national indicators has predominately focused on measuring safety and quality in hospitals. However, in May 2012, the Commission released a set of 35 safety and quality indicators for primary care.¹⁰³

The indicators cover seven domains, which are:

1. Accessibility

2. Appropriateness
3. Acceptability / patient participation
4. Effectiveness
5. Coordination of care
6. Continuity of care
7. Safety.

A full list of the practice-level safety and quality indicators for primary care can be found at the [Commission's website](#). The indicators were designed to be used voluntarily by primary care services to support quality improvement at the local practice or service level.

Why do this work?

Safety and quality benchmarks and target patient outcomes have not been specified, measured, monitored or reported systematically for primary care at either regional, state or national levels in Australia.⁸⁹ The lack of appropriate data and information about the safety and quality of care provided by primary care services has been identified as a significant barrier to improvement.^{17, 33, 89, 104}

Indicators are commonly used by health service organisations for internal evaluation and governance as well as external evaluation.¹⁰⁰ They have a central role in quality improvement by helping guide reflective practice, monitoring trends over time and identifying significant issues or variances in practice that would benefit from intervention.^{24, 103}

The Australian Government Department of Health is working on two projects that consider how existing data collection and reporting arrangements for primary care services can be amended or streamlined. One of these projects is the Practice Incentives Program Redesign. This project aims to support general practices to improve their detection and management of chronic conditions, and to focus on issues specific to their practice population. Practices participating in the new quality improvement incentive would use data to drive continual improvements in the care provided and measure their performance over time. The second project is working towards creating a Primary Health Care National Minimum Data set. This data set would contain de-identified information and help primary care services and the department to measure and benchmark performance at a local, regional and national level to inform policy. This activity forms part of the Health Care Home trials and was announced by the Prime Minister in March 2016 as part of the *Healthier Medicare* reform package.

These two projects aim to build a national data collection and reporting framework for primary care to meet current and future information needs. The Commission's work on reviewing the practice-level safety and quality indicators for primary care may help to inform these projects. Practice-level indicators can support primary care services to review their safety and quality performance, including benchmarking performance against other services if the data is made widely available, and can help services to use information to drive safety and quality improvement in a targeted way.

What else?

The Commission has identified two strategies for action – development of NSQHS Standards for primary care services and a review of the practice-level safety and quality indicators for primary care – to improve safety and quality in primary care. Work on these two strategies commenced in 2017. While these strategies will be important, more work will

be needed before safety and quality improvement is effectively embedded in the organisation and operation of primary care services.

The Commission is seeking feedback from primary care sector stakeholders about other safety and quality priorities and strategies that should be explored and implemented.

The *Australian Safety and Quality Framework for Health Care* and the available evidence about effective patient safety solutions may be useful to stakeholders when thinking about safety and quality strategies to be developed for primary care.

The Framework identifies a number of potential strategies under each core principle:

1. Consumer-centred care:
 - Developing and supporting models of integrated care across the primary and acute care sector
 - Using strategies such as shared decision making to engage consumers, patients, carers and families in their care
 - Designing and organising primary care services to better meet the needs of all patients and consumers, particularly those with low levels of health literacy.
2. Driven by information:
 - Using agreed clinical guidelines and standards to reduce unwarranted variation
 - Systematically collecting and reviewing information about patient outcomes, patient experience, processes of care and patient safety incidents to improve safety and quality.
3. Organised for safety:
 - Expanding the use of electronic tools including electronic records, electronic prescribing systems, alerts and decision support tools, and linking with My Health Record
 - Implementing standards for safety and quality in primary care services.

A scan of the evidence conducted by the UK's Health Foundation identified a number of patient safety improvement strategies used in primary care internationally that may be applicable in the Australian context.¹⁰⁵ These include:

- Systems for identifying, recording and analysing patient safety incidents
- Support for staff education and training in safety and quality
- Patient-centred care strategies, shared decision making models and increased access to information for patients about their care
- Use of collaborative networks to drive improvements in performance in specific areas
- Improvements to the coordination between primary, secondary and tertiary care practitioners through structured clinical handover
- Expansion of the roles for other practice team members
- Electronic tools, such as record management systems, prescribing systems, alerts and decision-support tools.

Many primary care services in Australia may already be implementing one or more of the strategies identified by the Framework or the UK Health Foundation. In addition to feedback from stakeholders on potential strategies for implementation, the Commission is keen to hear from primary care stakeholders about strategies that are already being implemented.

The Commission is seeking to understand the status of the implemented strategies and how they could potentially be systematised as part of a national approach to patient safety and quality improvement for primary care.

Details on how feedback can be provided are outlined in the next section.

7. Provide your feedback

To ensure the Commission's program of work to support safety and quality improvement in primary care meets the needs of the sector, the Commission is seeking your feedback.

You can contribute to this process by providing comments in writing, by letter or email. You may also call the Commission to discuss the consultation paper and provide your comments.

Submissions received may be published on the Commission's website, including the names and/or organisations making the submission. The Commission will consider requests to withhold part or all of the contents of any submission made. If requested, any submission that includes personal information identifying specific individuals may be withheld from publication or de-identified before submissions are published.

Submissions should be submitted by close of business on **22 December 2017** to be considered in the consultation process.

Submissions should include:

- Name, organisation (if relevant) and contact details
- Responses to the consultation questions
- Any general comments
- Additional information, for example, any technical, business information or research-based evidence the Commission should be made aware of.

Primary care stakeholders and consumers are invited to provide a submission. Questions have been provided to help respondents prepare their submissions. Questions 1-5 are targeted primarily at primary care service providers and organisations that provide support to them. Question 6 is targeted toward consumers that have used or use primary care services.

Submissions are invited to address any or all of the following areas:

1. The scope of primary care services as the focus for the Commission's program of work.

The consultation paper defines primary care services as:

'services provided by general practitioners, practice and community nurses, nurse practitioners, allied health professionals, midwives, pharmacists, dentists and Aboriginal and Torres Strait Islander health practitioners either, in the home, general or other private practice, community health services and local or non-government services'

Do you consider this to be an appropriate definition of primary care? Should this definition be amended? If so, what should be addressed in an alternative definition of primary care?

2. Safety and quality issues in Australian primary care services.

What are the safety and quality issues experienced by you, your primary care service or the primary care services you support?

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

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

What additional strategies, tools or resources should be developed and/or made available to make these strategies more effective?

3. Developing a set of NSQHS Standards for primary care services other than general practices.

What are the barriers and enablers for implementation of these standards in primary care?

How could the Commission address these?

What support could other organisations provide for implementation?

Which organisations need to be involved in this process?

4. Reviewing the Commission's practice-level safety and quality indicators for primary care.

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

How could the Commission address these?

Which organisations should be involved and what is their role?

5. Safety and quality improvement in primary care more generally.

What strategies are you, your primary care service or the primary care services you support, implementing to improve safety and quality of care? For example, do you have an incident or risk register in your service?

What strategies, tools or resources to support improvements in safety and quality should be considered?

What safety and quality strategies, tools and resources can be led by the Commission in a national approach?

What safety and quality strategies, tools and resources can be led by professional support organisations?

What are the barriers and enablers for implementation of these?

How could the Commission support implementation of these?

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

6. Primary care consumers.

What are your biggest safety and quality concerns?

What action would you like to see taken to address these concerns?

Can you provide examples of a safe, high-quality primary care service that you have visited? What did they do to support safe, high-quality care?

Does your primary care service support you to engage in your care?

Are you supported to involve your family, carers and/or friends in your care?

Does your primary care service support you to be involved in decisions about your treatment options?

Are you supported to communicate your wishes and goals for treatment?

When you visit primary care services, do you have an opportunity to provide feedback to the service on your experience of care?

Does the primary care service keep consumers and patients informed about changes they make in response to feedback they receive?

Submissions can be emailed to NSQHSStandards@safetyandquality.gov.au or sent by post to:

Patient Safety and Quality Improvement in Primary Care
Australian Commission on Safety and Quality in Health Care
GPO Box 5480
SYDNEY NSW 2001

Questions relating to the consultation process should be directed by email to accreditation@safetyandquality.gov.au or by calling the Commission on 1800 304 056.

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