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Royal Australian College *of* General Practitioners

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Dear Adjunct Professor Picone

**Re: National Safety and Quality Primary Healthcare Standards**

The Royal Australian College of General Practitioners (RACGP) has previously provided feedback to the Australian Commission on Quality and Safety in Health Care (the Commission) regarding its then proposed National Safety and Quality Primary Healthcare Standards (NSQPH Standards) in December 2017 and June 2019. Dr Louise Acland, Chair of the RACGP Expert Committee – Standards for General Practices (REC-SGP) also provided feedback to you on the NSQPH Standards in writing on 25 May 2020 and by teleconference on 25 June 2020.

The RACGP supports efforts to improve patient safety, avoid duplication, and improve communication and collaboration between all primary healthcare providers as well as with the acute sector. Given the extensive experience of the RACGP in writing standards, we previously offered to work with the Commission to support development of sector specific standards for use in other primary healthcare settings.

However, the NSQPH Standards present an identical framework for all primary healthcare settings, which discount the variation and nuances of each primary healthcare area to which they apply. We maintain our recommendation for the Commission to work with individual primary care stakeholders and experienced primary care standards setters to develop a fit-for-purpose framework relevant to specific primary healthcare settings.

Notwithstanding the above, the RACGP acknowledges the Commission's draft NSQPH Standards and welcomes public consultation in order to ensure its appropriateness and applicability across various primary healthcare settings.

## 1. Standards for general practices

The RACGP notes that, in the introduction to the NSQPH Standards the Commission states:

- a service's implementation of the NSQPH Standards is voluntary
- '*not all actions in the NSQPH Standards will apply in all primary healthcare services*'
- the NSQPH Standards '*may be particularly useful for primary healthcare services where safety and quality standards do not currently exist or where primary healthcare services are ineligible to be assessed against relevant profession-specific standards.*'

The RACGP recommends that the NSQPH Standards, and any relevant communications, make it clear that profession-led standards are already in place for any service that meets the RACGP's definition of a general practice and that the NSQPH Standards are not applicable to those health services.

The RACGP *Standards for general practices* (5th edition) (RACGP Standards) form a foundational benchmark for quality and safety in Australian general practice. We robustly piloted the RACGP Standards with Australian general practices (the profession for which they are intended) and consumers (the patients they protect). An expert committee consisting of GPs, academic GPs and nurses, practice managers, and consumer representatives oversaw development of the RACGP Standards. The RACGP Standards have been awarded accreditation by the International Society for Quality and Safety in Health Care' (ISQua) External Evaluation Association, which means they have been independently assessed as having met international best practice benchmarks.

While the draft NSQPH Standards introduction notes there are existing profession-specific standards for general practice, it in effect encourages general practices and other health services to meet both sets of standards, and therefore promotes unnecessary duplication. Primary healthcare services may be confused about conflicting messaging and the expectations of the NSQPH Standards where profession-led standards already exist.

As previously agreed, on a number of occasions, the scope of the NSQPH Standards should be limited to primary healthcare services that do not have existing standards, including general practice. It is important that this be made explicit in the NSQPH Standards document, as per previous statements made by the Commission both publicly and to the RACGP regarding their scope.

**2. Gap analysis for general practice requirements**

There are areas covered in the RACGP Standards that are not addressed in the NSQPH Standards. The gaps between the two sets of standards further highlight the completeness of the RACGP Standards for the general practice setting and the limitations of attempting to apply identical standards across all primary healthcare settings.

Areas that are essential for safety and quality in general practice (and in many cases other non-general practice primary healthcare services), which covered in the RACGP Standards and missing from the NSQPH Standards include, but are not limited to:

- *After-hours care* – the ongoing relationship between a patient and their primary healthcare provider or GP on a 24-hour basis (ie the patient's preferred practitioner providing or putting arrangements into place for after-hours care).
- *Information security* – maintaining the security of computers and other devices for the sake of health information privacy and compliance to legislative requirements regarding privacy and confidentiality.
- *Practice facilities and equipment* – ensuring the environment in which the practice operates, including the building and the equipment, is safe and effective for the practice team and patients.
- *Cold chain management* – ensuring the potency of vaccines is maintained.
- *Research* – ensuring that when research occurs, the collection, use and disclosure of data comply with privacy laws.
- *Training of non-clinical staff* – supporting the vital role administrative staff and other non-clinical staff have in the provision of safe and quality care by ensuring they have training appropriate to their role.

These gaps emphasise that general practices already assessed against the RACGP Standards should not need to, or be encouraged to, be assessed against the NSQPH Standards.

**3. General feedback on NSQPH Standards**

The RACGP appreciates the Commission's consideration of previous feedback submitted regarding the development of NSQPH Standards.

Having reviewed the current draft NSQPH Standards, we have further feedback for the Commission on the document, as outlined under the relevant sections below.

*3.1 General comments*

3.1.1 The draft NSQPH Standards have retained explanatory notes providing additional detail for each criteria, which may assist the users to contextualise the requirements in various settings. Any additional explanatory notes and supporting resources must be provided by the Commission at the same time as the NSQPH Standards to ensure primary healthcare services are equipped to understand each criterion. The draft refers to a suite of resources becoming available to support the implementation of the NSQPH Standards 'by providing practical guidance and assistance.' The NSQPH Standards document and associated supporting resources must appropriately cross-reference one another.

3.1.2 In some criteria, the items and actions within the explanatory notes are very specific, while in others the requirements are very broad. For example:

- The explanatory notes for 'Standard and transmission-based precautions' (3.01) state a requirement for the service to identify and mitigate all infection and prevention control risks; however, this requirement is not reflected in the action itself.
- The explanatory notes for 'Workforce immunisation' (3.08) state a requirement for a documented process for any members of the workforce that refuse vaccination; however, this requirement is not reflected in the action itself.
- The explanatory notes expand on who the action is applicable to, rather than providing advice on how to address the action (eg 1.12 'This action applies to primary healthcare services with primary healthcare providers authorised to view and add patient health information to a patient's My Health Record').

Consistency of expectations is important to ensure the level of compliance is communicated at a similar level across the NSQPH Standards.

*3.2 Specific feedback - Clinical Governance Standard*

3.2.1 Feedback and complaints management is important for the management of clinical risk, recognised at action 1.07. However, patient feedback can also enhance quality improvement and risk mitigation for non-clinical aspects of the primary healthcare service (eg access to the service or communication of non-clinical staff). Actions in the NSQPH Standards relevant to feedback and complaints do not reflect a need for the service to respond to the feedback. The Commission could consider expanding these actions so that primary healthcare services collect, implement and respond to all patient feedback and complaints, clinical or not.

3.2.2 Throughout the 'Patient safety and quality systems' criterion, various references to patient access are made, including for diverse and high-risk groups (1.09). No reference is made in this section to interpreters ('English as a second language' is referenced, but not 'Patients with low/no English proficiency'). All primary healthcare settings need to consider the use of interpreters so practitioners can effectively communicate health information to patients. Appropriately qualified medical interpreters are the preferred choice. Similarly, the provision of translated resources could be recommended across all primary healthcare settings.

3.2.3 The 'Safe environment for the delivery of care' criterion does not ask primary healthcare services to provide equipment for the safe care of people with disabilities (eg height adjustable beds). Primary healthcare services need to ensure that members of the clinical team can access the equipment they need to provide comprehensive primary care to patients.

3.2.4 Actions related to My Health Record (1.12, 1.13) expect health care services to meet various requirements if the service contributes to and obtains information from My Health Record. These actions need to be well supported with resources to assist primary healthcare providers who have problematic access to the My Health Record (MHR). These actions do not refer to the health service obtaining information already in My Health Record. The Commission could consider including advice that where information is obtained and confirmed as incorrect in the MHR, the provider responsible for the information is informed.

3.2.5 Variation in care delivered by providers and health outcomes for patients (1.21) is an important, but challenging action that is not possible for individual healthcare services to control. In order to identify significant variation, primary care providers will need reliable and accurate information about acceptable performance, and the performance of their peers.

3.2.6 The 'Safe environment' action (1.22) asks that services 'maximise safety and quality of care through the design of the environment.' This action is clearly desirable, but many primary healthcare services will not have the ability or resources to design all elements of their environment. The NSQPH Standards should retain this action, but it could be more specific, ie consider '*design of those elements of the environment within their ability.*'

*3.3 Specific feedback - Partnering with Consumers Standard*

3.3.1 Information about services available, opening hours, costs, etc. is provided under the 'Health literacy' action (2.08). Providing this type of information to patients has broader application than health literacy and we recommend cross-referencing this section with criterion 'Partnering with patients in their own care'.

3.3.2 In addition to the above, action 'Accessing primary healthcare service information' (2.08) could be expanded to include 'in the after hours', as some primary healthcare services will have different information and requirements after hours.

*3.4 Specific feedback - Clinical Safety Standard*

3.4.1 The RACGP supports the requirement for primary healthcare services to have strategies and practices to provide culturally safe services to meet the needs of its Aboriginal and Torres Strait Islander patients (1.15). The RACGP recommends that such action include workforce training to ensure safe and effective care for other cultures within the service's patient community.

3.4.2 Reference to patient recalls is made at the 'Communicating for safety' criterion (3.27), but there is no information regarding patient reminders, or a distinction between the two actions. Across relevant primary healthcare settings, a reminder system needs to be employed to ensure patients undergo regular screening and checks relevant to that setting. A reminder process should be independent of the system used for recalling patients with clinically significant results.

3.4.3 Several references are made to the *Australian Guidelines for the Prevention and Control of Infection in Healthcare* throughout the 'Preventing and controlling healthcare-associated infections' criterion. These guidelines are a national resource that apply to all healthcare settings, including hospitals.

While the draft NSQPH Standards stipulate that the guidelines are suitable for all health care settings, this extensive document could be inaccessible to smaller healthcare services. An 'office based practices' targeted document might be more appropriate (such as the RACGP's *Infection prevention and control standards*). Alternatively, the Commission could consider developing associated resources to support services to navigate what is required within the national guidelines in a primary care environment.

3.4.4 Understanding information on likely patient aggression and violence may be important for comprehensive care; however, in the broad sense that it is presented, the NSQPH Standards requirement to predict, prevent and manage aggression and violence (3.21) is more applicable to workplace health and safety. We recommend moving this item to the 'Safe environment for the delivery of care' criterion and adding staff education and training for relevant providers (ie training to identify and mitigate aggression and violence).

3.4.5 'Comprehensive care at the end of life' (3.20) may be outside of scope of practice for a number of primary healthcare providers. This is not reflected in Appendix 1 'Not applicable actions'. We have similar concerns regarding the scope of 'Recognising acute deterioration or distress and escalating care' (3.23), as not all providers will be equipped to recognise acute deterioration or distress, also not reflected in Appendix 1.

## 4. Existing framework for the development of primary healthcare standards

The RACGP Standards use a modular structure designed specifically for the purpose of broader application. With some necessary contextualisation, the RACGP's Core and Quality Improvement modules are already relevant for all primary healthcare settings.

The RACGP is open to the development of new modules for specific primary healthcare settings that can be tailored to be fit-for-purpose. For example, we are currently developing modules for prison health services and for immigration detention facility health services. We would welcome working with the Commission and relevant peak bodies to deliver such standards in the future.

If you would like to discuss any of the matters raised in this letter, please contact me or Mr Roald Versteeg, General Manager – Government Relations, Policy and Practice, via email at roald.versteeg@racgp.org.au or by phone on (03) 8699 0408.

Yours sincerely

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