Royal Australian College of General Practitioners (RACGP's) response to Review of general practice accreditation arrangements consultation

Background/ Introduction

Development of the *Standards for general practices*

The Royal Australian College of General Practitioners (RACGP) commenced the development of profession-led standards in 1991 with the support of the Australian Medical Association and the Australian Department of Health. The principles were that accreditation of profession-led standards should:

- aim to attain the highest quality of general practice in an achievable and gradual manner
- provide a publicly recognisable measure of quality in general practice
- be voluntary, but have tangible benefits
- be for a defined period
- be an education and developmental process and not a punitive one
- be in the hands of the profession.

Following extensive development, field testing and demonstration trials, *Entry Standards for General Practices* were published in 1996.

The fifth edition, launched in October 2017, is the current version of the *Standards for general practice* (Standards). Development used best-practice Australian and International evidence and/ or Level IV evidence (panel of experts where evidence is not available). Evaluation used a modified Delphi framework, requiring cycles of consultation and piloting. The Standards are accredited by the International Society for Quality in Health Care.

The current edition saw a shift in language to be patient-centred and outcome (as opposed to process) focussed. The continued evolution of general practice teams has been reflected within the Standards as well as the emerging e-health/ technology agenda allowing for evolving national e-health initiatives including standardised electronic health records and unique patient identifiers.

Digital publication has also enabled a more dynamic response to external pressures and legislative changes, with an update to the current edition underway to reflect the change in the way general practices have provided care during the COVID-19 pandemic (i.e., Telehealth now able to be billed via the Medicare Benefits Schedule).

Better recognition of consumer rights and the importance of gaining their feedback was introduced in the third edition Standards. The utilisation of patient feedback in practice quality improvement activities has been expanded with each edition and reflected through:

- the patients experience of the care provided
- experience in accessing the practice and their preferred practitioner
- informing patients of changes made by the practice in response to their feedback.

Development of new criteria within the Standards has ensured alignment with the requirements of the National Safety and Quality Health Service Standards.

National General Practice Accreditation Scheme

The National General Practice Accreditation Scheme was established in response to the recommendations of the Australian National Audit Office Report on the Practice Incentives Program in 2010. One of these recommendations was for the Australian Commission on Safety and Quality in Health Care (ACSQHC) to have a greater role in the oversight of general practice accreditation.

The NGPA Scheme was developed by ACSQHC, in collaboration with the RACGP, and commenced on 1 January 2017.

The RACGP has continued to participate with the administration of the NGPA Scheme via:

- Membership on the ACSQHC's General Practice Accreditation Coordinating Committee.
- Membership on the ACSQHC's Primary Care Coordinating Committee.
- Position on Accreditation Agency assessment panel for admissions to the NGPA Scheme.

The NGPA Scheme:

- provides a framework for general practices to be assessed against the Standards
- provides greater choice for general practices seeking accreditation
- improves support programs for implementation of accreditation.

Australian Department of Health

The Practice Incentives Program (PIP), administered by Services Australia on behalf of the Department of Health, provides incentive payments to practices accredited, or registered for accreditation, against the Standards. There are nine individual incentives available under three payment streams to incentivise specific practice activities, as per government priorities.

Australian General Practice Training program

Transition of the Australian General Practice Training (AGPT) Program to the general practice colleges was announced by the Federal Minister for Health, the Honourable Greg Hunt, in 2017. As a result of this commitment, Australia finds itself at a transformative moment in specialist medical education history. We have an opportunity to reform the nation's general practice education and training system to provide significant, meaningful improvements in the quality and safety of training and the distribution of general practitioners (GPs) for the long-term benefit of the community and the profession.

The RACGP has drawn on best-practice research and evidence, together with the experiences of its members, expert advice and broad sector consultation, to develop RACGP's vision for general practice education and training. This vision encompasses fundamental changes to the current training system that will achieve a sustainable pipeline of safe, competent and confident GPs and rural generalists (RGs). The proposed model seeks to retain the most effective features of the current AGPT Program, while creating a more nationally consistent, efficient and locally responsive approach.

The RACGP's proposed operating model for its vocational training program is community-focused, built on a foundation of high-quality supervisors and training sites with which there is already an established relationship and trust.

The return of general practice training to the RACGP provides a unique opportunity to reform training and secure the future of Australia's primary health system. For the community, the RACGP model will work towards ensuring GPs are available where they are needed, can meet the challenges of the future, and can work in the health systems of tomorrow. For registrars, the model will provide improved flexibility in their training pathway and region, and a more personalised, higher quality training experience, making general practice a more desirable and rewarding career choice. For supervisors, the model will align professional development and payments nationally, provide a local point of engagement for training administration and deliver targeted support to build supervisory capability in areas of need.

Consultation Response

Section: General Practice Consultation

1. What are the benefits of accreditation to general practices, GPs and other staff and patients?

Standards are a benchmark for quality care and risk management in Australian general practices. They were developed with the aim of engaging the profession in a comprehensive process of continuous quality improvement.

The significant benefit of accreditation is the independent assessment of systems and processes that deliver safe care and high-quality outcomes within a patient-centred framework.

Other benefits include strengthening:

- continuous quality improvement
- role of the practice team in quality activities
- monitoring of patient population for preventative care, screening or best-practice management of health conditions
- input of patient feedback to guide practice improvement
- identification and mitigation of risk
- clinical risk management and clinical governance
- consistent access to a standardised level of care and quality of service provision to patients.

Accreditation also allows practices to participate in the Practice Incentives Program, where practices can receive additional funding if they undertake additional activities, which often change as per the government's priorities.

2. What are the barriers to accreditation and to the achievement of the overarching outcomes sought from accreditation (e.g. continuously improving quality and safety)?

Cost

The RACGP is unable to comment on the direct costs of accreditation as there is no oversight of how the accreditation agencies set their fees. The principles of a community rating being applied to the costs of general practice accreditation is discussed in our response to Question 15.

There are indirect costs that will vary depending on the skills and experience of the general practice team, the maturity of practice systems and processes, and whether the practice has been accredited previously. This may be a barrier for practices new to accreditation or those that do not have a dedicated practice manager or additional team members they can call upon to share the load in the development of systems and processes.

Perceived value and effort

Historically, the Standards specified the way in which practices needed to demonstrate adherence to the requirements. The fifth edition was written to be outcomes focussed, enabling practices to demonstrate the systems and processes they use to meet the requirements. The intention of this change was to make accreditation less onerous and more reflective of the way the practice already works.

The current cycle of accreditation against the Standards is 3-years. The process requires general practices being assessed to provide evidence via a range of mechanisms (document review, staff interview, inspection) at an on-site visit. This visit is undertaken toward the end of the cycle and on a date which general practice are provided with significant advance notice (announced visits). There is some evidence that perceived staff effort is less for short-notice accreditation process than an announced visit (see Appendix 1).

The RACGP has been investigating an alternate process of accreditation. Such a process will seek to engage practices across the entire accreditation cycle, use technology and data aggregation tools to survey on some of the indicators and to include an unannounced visit. The intention is to promote a continuous approach to improvement and to leverage technology and data to reduce the effort involved in accreditation. There may also be an advantage of reducing the intensity of effort at a single point in time which is appealing to practices in managing the resources that support accreditation.

3. What are the strengths and limitations of the current governance arrangements for the NGPA Scheme?

The RACGP supports the coordinating function intended by the establishment of the NGPA Scheme. However, there is a lack of clarity about the roles and responsibilities of the RACGP and the ACSQHC as well as the authority for each contribution to the NGPA Scheme. There are many examples of the ACSQHC issuing an advisory that effectively creates new requirements for accreditation.

The current governance structure does not include the organisation with responsibility for the policy intent for funding of general practice care and quality practice. The Department of Health creates funding and incentives for a range of policy objectives including quality, training, workforce and sustainability of general practice. Moreover, the recent recommendations for the 10 Year Primary Care Plan seek to link funding to patient enrolment, recognising that continuity of care is a driver of good outcomes.

The operational management and implementation of the NGPA Scheme needs to mature to include appropriate collaboration and consultation with all contributors to the NGPA Scheme.

4. How could the governance be improved, including to ensure clarity of purpose, roles and responsibilities and to support continuous improvement and drive confidence in the NGPA Scheme?

The RACGP supports a governance framework that reflects the authorship of profession-led standards (RACGP), the agency who oversees the assessment of this content under the NGPA Scheme (ACSQHC) and the body associated with funding patient healthcare via the Medicare Benefits and to practices under the PIP (Department of Health).

In addition, the Department of Health should be represented on the General Practice Accreditation Coordinating Committee.

To establish such a mechanism would lead to open and clear communication between all parties that have a critical role in the mechanisms to support quality general practice care.

Future governance could consider the Department of Health as the centralised and coordinating function, especially considering their oversight of the funding to general practices in Australia.

Section: The Standards

5. What are the strengths and limitations of the current Standards for general practices?

A key strength of the Standards is the profession-led, consultative approach in Standards development and maintenance. This means that the Standards are developed with practice staff, clinicians and consumers both directly and through the experience of their clinicians. This results in focused activity, practicality and continual improvement by clinicians and practice staff, for consumers. This approach recognises that subject matter expertise is crucial in ensuring that the Standards remain relevant into the future while continuing to advocate for quality and patient safety in primary care. This is achieved through extensive consultation using a Delphi model guided by a representative expert panel with clinical expertise in general practice, Indigenous health and emergency medicine. The expert panel consists not only of GPs but also practice nurses, practice managers, and consumer representatives. This approach has meant that there is wide acceptance of the Standards by the profession.

Another key strength is piloting of the Standards in a wide variety of general practice settings. This includes general practices in rural and urban location, solo, small and large practices (based on full time equivalent of GPs), corporate and private business models as well as Aboriginal Medical Services. The wide range of pilot settings ensures that the Standards are applicable in a wide variety of primary care settings while remaining relevant to the profession.

The outcomes-focused approach of the Standards is another strength as it allows general practice the flexibility on how they can meet an indicator. This approach allows practices to tailor their processes and systems to what works best for their own structures. The outcomes-focused approach puts the patient at the centre of the service, acknowledging the role that general practices play in providing continuous and comprehensive care.

Finally, the modular structure of the Standards allows for greater flexibility and enables ongoing review and updates to the Standards as required following their release. This allows the RACGP to be responsive to the changing primary health environment. In addition, the flexibility of the modular structure means that the Standards can be adapted to different settings that are involved in the provision of general practice services such as immigration detention facilities, prison and residential aged care.

6. How could the Standards for general practices be improved, particularly to ensure they are practical and meaningful for all general practices, remain relevant into the future and do not impose unnecessary regulatory burden on general practices?

The Standards are responsive to changes in the primary care landscape. Reviews are undertaken regularly to ensure that it remains pertinent to the profession and the patient population to which it serves. For example, the RACGP is currently in the process of updating the Standards with the latest evidence-based guidelines and requirements for telehealth consultations and infection prevention and control measures brought upon by the COVID-19 pandemic. In addition, the RACGP is also updating the collection and recording of patient-assigned sex at birth (sex) and gender identity (gender) requirements in the Standards. These requirements recognise that patients may not identify as exclusively male or female or may identify as a gender other than the sex they were assigned at birth and the importance for this to be accurately recorded in their patient health records, if they wish for it to be.

The RACGP is supportive of every effort to reduce regulatory burden on general practices and acknowledges that there may be duplication in the various accreditation schemes that some general practices may be exposed to. More information is available in the response provided to consultation Question 19.

As noted in Question 2, the RACGP is exploring an alternate process of accreditation. One of the proposed benefits is the potential to reduce the intensity of effort at a single point in time which is appealing to practices in managing the resources that support accreditation.

The review of general practice accreditation is an opportunity for the RACGP to consider feedback to continue to streamline the effort required by practices to meet the Standards.

Section: Standards assessment

7. What are the strengths and limitations of the requirements for (and oversight of) accrediting agencies?

There is value in requiring all accreditation agencies to be accredited by a recognised accreditation body, such as the International Society for Quality in Health Care (ISQua). However, given that there are different international accreditation bodies, each with different requirements and expectations of the agencies they accredit, there is scope for varying levels of assessment and differences depending on which body an agency chooses.

Regarding surveyor workforce specifications, surveyors must:

- demonstrate a good understanding of confidentiality issues relating to general practice, personal health information and patient privacy
- meet requirements relating to their previous and recent experience
- complete ongoing surveyor training as required by the NGPA Scheme to maintain their competence and knowledge of the Standards.

GP surveyors must have at least five years' full-time or equivalent part-time experience as a vocationally registered GP and be working at least two sessions a week in face-to-face patient contact in an accredited general practice, and have done so for the last two years, or have worked at least two sessions a week in face-to-face patient contact in an accredited general practice within the last two years.

Non-GP surveyors must have at least five years' full-time equivalent experience and must be working at least 16 hours a week in an accredited general practice, and have done so for the last two years, or have worked at least 16 hours a week in an accredited general practice for at least two years, and not more than two years ago.

Relating to performance, agencies are required to prevent bias, manage conflicts of interest, maintain ethical and lawful conduct and ensure that they have assessment methodologies and processes that support independent assessment. These and further requirements placed on surveyor teams ensures that surveyors are keenly experienced in general practice, but also restricts professional surveyors from other sectors servicing general practice, who could bring to general practice a potentially broader scope of accreditation knowledge and less professional bias.

In relation to data requirements placed on agencies, there is currently no requirement for intra-agency data reporting, meaning there is no way to see in the data what consistencies and inconsistencies occur among the surveyors for a given agency.

Both the RACGP and ACSQHC collect accreditation compliance data from the accreditation agencies, via licensing requirements and approval into the NGPA Scheme respectively. The data requirements of and use by each organisation is different and has resulted in inconsistencies between the variables requested and templates/ format provided for submission. This sees duplication in data submitted by the accreditation agencies, resulting in significant frustration by the agencies. Further discussion on this issue can be found at Questions 8, 17 and 18.

8. How could the arrangements relating to accrediting agencies (including for surveyors) be improved?

The RACGP believes that improved governance arrangements for all stakeholders of the NGPA Scheme be improved to better coordinate all accreditation arrangements.

Streamlining data provision processes for the agencies is needed. The RACGP and ACSQHC could work together to identify the data requirements of both parties and incorporate these into a consistent request. This could be further expanded to triangulate the PIP information required by the Department of Health, including variables of the Quality Improvement incentive. The RACGP acknowledges that such an expansion would involve costs to develop systems to collect and monitor the data/

Another opportunity for improvement for the consistent application of the NGPA Scheme as it matures is a framework for assessing agency variability in support provided to general practices seeking accreditation. This would encompass a range of components including (but not limited to) resource provision, portal capabilities, general practice self-assessment process and reporting to the candidate general practice (including who is engaged to support this step). The RACGP acknowledges that it is for each agency to determine how they meet their requirements to the NGPA Scheme and so careful consideration would be required if the NGPA Scheme was to include more detail on such a requirement.

Further arrangements could be expanded to include the development and implementation of a monitoring system to oversee the consistency of surveyor assessments. This would be both within and between each accreditation approved under the NGPA Scheme. Careful consideration would need to be given to the parameters that such monitoring would include and the RACGP would need to be directly involved to ensure the intention of requirements informs such a system.

Another improvement is the oversight and provision of surveyor education by the RACGP or ACSQHC. This would enable great consistency across for surveyor knowledge and interpretation of the Standards.

Further investigation is also needed to consider the potential impact of accreditation agencies being accredited by differing and multiple accreditation bodies. There may be an opportunity to increase consistency and decrease cost to accrediting agencies.

Section: Assessment approach

9. What are the strengths and limitations of the assessment approach?

The current assessment approach is well established and a familiar process to general practices, with 84% of practices currently accredited (and over 80% accredited in all states and territories except Northern Territory), a percentage which has continued to increase over the last decade. However, familiarity does not confirm the strength of the assessment approach, as there is currently no alternative model to compare it to.

The current assessment approach includes visits that:

- occur at a single a point-in-time – meaning it does not innately facilitate continuous quality improvement over each accreditation triennium and places a periodic and therefore costly strain on practice resources.
- are restricted to face-to-face assessment, with no option for remote assessment or other virtual assessment elements.

- provide significant advance notice – meaning it does not capture the ‘every day’ of general practice, as practices prepare specifically for assessment day, ie it does not identify the ‘business as usual’ true practice strengths and weaknesses (conformities and non-conformities).

The cessation of accreditation in early 2020 due to the COVID-19 pandemic made the concept of a continuous, remote, desktop assessment more compelling.

The current assessment approach also includes a three-year cycle; however, there is a lack of evidence for the preferred length of accreditation cycles in Australian general practice.

While there are several mechanisms in place to support consistency in accreditation approach, these mechanisms exist in isolation and have not been tested against other mechanisms to support consistency.

The limitations to the assessment approach do not mean that the current accreditation approach is insufficient, but there is scope to test the current model against other models to see what changes would be beneficial.

10. How could the assessment process be improved, including to drive quality and safety, enhance confident in the NGPA Scheme and minimise unnecessary burden?

The current process is perceived as being resource intensive around a point-in-time and encouraging short-lived quality improvement. There are opportunities to modernise general practice accreditation using design and technology to encourage continuous quality improvement, while at the same time allowing improved workload management for the clinical and practice team.

There is scope to identify improvements in the assessment process by trialling alternative models of assessment and comparing those with the current approach. There are many hypotheses that can be tested by trialling a new model or models and investigate the impact on:

- staff requirements for accreditation preparation
- time for accreditation preparation
- streamlining processes, ie consistency in subsequent and ongoing accreditation of a practice
- pressure to upload documentation required in a concentrated time frame
- changes to the practice mindset regarding accreditation, with a new focus on continual improvement rather than demonstrating compliance at one set period of time
- confidence in the currency of accreditation.

The NGPA Scheme could look at ways to improve the consistency of accreditation across agencies by:

- improving assessment methods for accreditation assessors to increase clarity, efficiency and consistency in interpretation and assessment
- providing assessors with tools that support a systematic approach to accreditation
- ensuring assessors are given opportunities to discuss and feedback on the outcomes of their assessments
- increasing and maintaining audits and reviews of practices undergoing accreditation, with feedback fed into continuous improvement of the processes
- introducing third party evaluation (eg independent committee/audit) of an accreditation agency’s assessment and determinations (including whether remediation is required) could be introduced to assess the effectiveness and consistency of assessors.

Section: Non-conformance or remediation

11. What are the strengths and limitations of the current approach to non-conformance and remediation?

A key strength of the non-conformance approach is that practices are provided up to 65 days (90 calendar days) to complete remediation. This gives practices sufficient time to address any material concerns identified through the on-site assessment and prepare for the audit assessment of indicators that have been assessed as 'Not met'.

A potential weakness in the current approach is the lack of clarity on how accrediting agencies are applying the rating scale. Transparency on rating thresholds used by accrediting agencies to determine non-conformance would provide a clearer picture on whether a non-conformance finding is related to a quality and patient safety issue or whether it is an administrative/ operational process issue. This will support the RACGP's understanding on how the Standards are being applied by general practices and assessed by surveyors, and to make future improvements or adjustments to the Standards. Further, this will also enhance the RACGP's analysis of the data supplied by the accrediting agencies to accurately identify trends and longitudinal changes in non-conformance.

While some interagency inconsistencies may be unavoidable, transparency on rating thresholds could minimise inconsistencies between accrediting agencies, provide the opportunity to standardise interpretation of the Standards and implement common guidance for general practices and surveyors.

There is also a lack of transparency around follow up processes for non-conformities between agencies.

12. How could the approach to non-conformance and remediation be improved, including to drive participation in accreditation, sustained conformance and commitment to continuous improvement?

The assessment approach to meeting the Standards using a dichotomous met/ not met criteria may not offer the nuanced picture of the practice's true level of performance, and commitment to continuous improvement. Such an assessment framework also means that there is reduced insight to the potential for inter-surveyor variability.

As described in the answer to Question 11, transparency on rating thresholds could minimise inconsistencies between accrediting agencies, provide the opportunity to standardise interpretation of the Standards and implement common guidance for general practices and surveyors.

It is also important to reiterate that general practice offers services to various populations of diverse demographics and healthcare needs, therefore a one-size-fits-all approach to participation in accreditation, and sustained conformance may not be applicable to all general practice.

Developing supplementary material to standardise the assessment process by the various accrediting agencies and adapting it to various settings could be a valuable approach to explore to drive participation in accreditation and commitment to continuous improvement. Appropriate licensing arrangements would be imperative to protect such a resource being provided by the agencies/ surveyors to practices preparing for their assessment.

Other accreditation approaches (that offer short term and ongoing quality assessments) as alternatives to the cyclical accreditation approach, have been explored by the RACGP as discussed in previous sections.

Section: Costs of accreditation

13. For accredited general practices: Please describe the:

a) direct costs involved in seeking accreditation (e.g. registration fees, travel and accommodation costs for on site assessment, etc.)

b) indirect costs in seeking accreditation (e.g. costs of staff time preparing for accreditation, establishing systems and processes to meet the Standards, preparing evidence to demonstrate conformance with the Standards, etc.)

This question is not within the purview of the RACGP to provide a response.

14. What are the strengths and limitations of the current approach to the setting of accreditation fees by accrediting agencies?

This question is not within the purview of the RACGP to provide a response.

15. What changes could be made to the way that fees are set and levied to promote participation in accreditation and ensure equity of access across different types of general practice?

The RACGP has no insight to the fees charged by the accreditation agencies due to commercial in confidence.

There has been a principle required of accreditation agencies licensing the Intellectual Property of the Standards from the RACGP and supported by the requirements under approval in to the NGPA Scheme. While this principle has commonly been referred to as 'community rating', there is no community rating requirement set by the RACGP or the NGPA scheme.

The RACGP Licensing Agreement and RACGP Standards for general practices states:

- A commitment [by an accreditation agency] not to refuse an application for accreditation from a practice that meets the RACGP's definition of a general practice, regardless of location or size.

- A commitment not to financially or otherwise discriminate against a practice because of location or size.

NGPA Scheme defers to the requirements within the Standards.

As stated above, currently there is no community rating framework for general practice accreditation (unlike private health insurance, for example, where the Australian Government standardised fees of private health insurance funds, ensuring "everyone is entitled to buy the same product, at the same price").

While there is no such formal mechanism in place for general practice accreditation, the RACGP would support the development of a formalised fee framework, which incorporates the principles articulated above.

16. What adjustments could be made to the NGPA Scheme to reduce unnecessary costs associated with accreditation while continuing to ensure a focus on quality, safety and continuous improvement?

As previously indicated, the RACGP's believes that improvements are needed to the governance structure of the NGPA Scheme. The RACGP has concerns that proposed approaches to improve oversight of the NGPA sometimes lack consideration of the general practice environment and context, and risk increased cost and burden to general practice and accreditation agencies with little benefit for patients. This is largely due to the predominant experience of the ACSQHC in the hospital environment and implementation of the associated schemes, and the lack of authority that the RACGP has within the governance structure. We believe that the RACGP and the Department of Health need to be equal partners with the ACSQHC in oversight of the NGPA scheme.

A recent example is a proposal by the ACSQHC for accreditation surveyors to interview patients as part of the assessment visit. The proposal had not been discussed with the RACGP or feedback sought on the applicability of this approach, taken from the acute setting and applied to the primary care setting. There was no evidentiary basis to the proposal which will have significant impacts on practices, their patients and accreditation agencies.

The RACGP supports an improved governance structure for timely communication and collaboration. Such an environment would acknowledge the importance of each individual organisation to the successful implementation of the NGPA Scheme.

Section: Data and transparency

17. What are the strengths and limitations of the current approach to data (reporting, analysis and use) and transparency?

Productivity Commission's Report on Government Services

The Productivity Commission provides a range of data relevant to general practice accreditation as part of its annual Report on Government Services (ROGS).

The ROGS provide data over several points in time, providing evidence of general practice accreditation trends in Australia. The ROGS is an important resource to demonstrate the current and historical state of accreditation allows users to make inferences about the next steps and recommendations about how to further improve care quality and accreditation.

The ROGS does not:

- inform users of compliance to Indicators in the Standards, or variation between practices and agencies
- provide evidence whether accreditation is associated with improved clinical outcomes or quality of care
- provide variational context (eg detail on why there are differences between regions)
- show which edition of the Standards general practices are accredited against (in years where there is an overlap of two editions), or whether certain events account for changes to accreditation rates
- report on accreditation activity by the new accreditation agencies.

Because of these limits, various hypotheses cannot be validated to gain more insight into the reasons why accreditation increased significantly across all states and territories during the study period.

Compliance data from accreditation agencies

Analysis of practice compliance data – provided by the accreditation agencies – can provide details on:

- compliance to Indicators in the Standards
- association between accreditation agency and overall compliance
- association between location (State and Territory, or rurality) and overall compliance
- association between practice size and overall compliance.

Compliance data can be used to:

- see where consultation is needed for improvements to the Standards, eg knowing whether compliance is most impacted by agency, location, practice size, etc.
- review Indicators within the Standards for feasibility, acceptability, achievability, and applicability.
- update explanatory notes in the Standards where needed, or developing supporting materials for general practices, eg fact sheets
- improve accreditation training eg where significant variation occurs between agencies for assessment of given Indicators
- plan of the 6th edition.

There is a challenge converting data (including accreditation and compliance data) from multiple sources consistently, reliably, and accurately into useful information and knowledge.

As with the ROGS data, there is also a lack of variational context in the compliance data. Further accreditation research and stakeholder consultation is needed to explain many of the observations found in accreditation data, such as:

- what impact changing Indicator compliance or accreditation numbers have on quality care, clinical outcomes, and consumer experience
- why some regions have lower proportions of compliance or accredited practices than others
- what events or resources may result in an increase or decrease in Indicator compliance and/or accreditation
- what aspects of accreditation agency performance impact their assessment of certain Indicators
- whether additional incentives or strategies are needed to support unaccredited practices to become accredited.

Conducting effective research and communicating data findings to stakeholders is currently restricted by existing service agreements with the agencies that prevent publication of the data provided to the RACGP.

18. How could the approach to data (reporting, analysis and use) and transparency be improved to drive quality, safety and continuous improvement by general practices and also in relation to the operation of the NGPA Scheme?

The approach to data and transparency can be improved with:

- A consistent approach to data provision – Consistent and clean data needs to be provided by the accreditation agencies, and transparently released under the NGPA scheme. An approach to data provision could be established collaboratively between the ASCQHC, RACGP, Department of Health, and agencies, but needs to result in a single format or set of formats for the provision of data.
- Timely provision of data – The timeliness of data provision needs to be at least maintained (it is currently provided monthly) or improved to ensure any information related to data is current and that necessary agency comparisons can be made.
- Permissions – Agencies need to provide permission to share de-identified data to communicate findings to the profession and to consult and work with third parties to translate data effectively.
- Discussion – All stakeholders who provide and receive data need to be open to discussing the data and its findings and implications. Discussion ensures that data is used openly and can create efficiencies in its application.
- Research and reporting – As per permissions above, further research and reporting on data is necessary to ensure it is used correctly and that any findings can be published.

Section: Intersection with other accreditation schemes

19. Describe any opportunities to reduce duplication across accreditation schemes impacting on general practices. For example, with training accreditation or accreditation to deliver additional health services.

The RACGP supports efforts to improve patient safety, avoid duplication, and improve communication and collaboration between the various general practice services and their relevant accreditation schemes.

The RACGP recognises that in some instances there are several accreditation schemes that a primary healthcare service might be required to achieve based on the services they provide. This also includes general practice services where one is included within a multidisciplinary site (i.e. some community health services provide access to a general practice, others do not). Where a provider is required to meet multiple sets of standards, they experience duplication in some of the systems and evidence needed (i.e., governance) to meet their obligations.

Fragmented funding arrangements between state and federal health departments creates an increased compliance burden for health services. Additionally, the requirements of such finding schemes risk creating silos of healthcare provision as performance requirements are contained to the funding schedule and not the environment in which the care takes place.

For example, community health services are funded by local and state governments. They have accreditation requirements to receive this funding. Community health services also seek additional funding opportunities based on the needs of their communities. Where a general practice is present, these services access the Medicare Benefits Schedule on behalf of their patents. However, funding for additional programs, such as mental health, alcohol and other drugs, the National Disability Insurance Scheme, MyAgedCare etc comes through siloed, state or federal schemes. Each of these additional streams have requirements of the receipt organisation to meet various standards resulting in duplication of some components.

The RACGP supports any efficiencies that enable multi-standard requirements to be achieved with reduced duplication. There are a range of middleware solutions that seek to address the multi-standard requirements within primary healthcare settings. Such solutions provide portals that map requirements (i.e governance) across a range of standards (and within a range of sectors). The RACGP has licensed the Standards to one of these providers for their customers to access a more streamlined accreditation experience when addressing their obligations. The RACGP will continue to support any providers that seek to incorporate the Standards for this purpose.

Section: Support for general practice

20. Describe any opportunities to improve the support available to general practices to drive engagement with accreditation and achievement of accreditation outcomes.

There are a range of supports available to accredited general practices, however it is fragmented, inconsistent and/or unknown.

The RACGP develops a range of comprehensive resources that support general practices establish their systems and processes, as well as frameworks to participate in quality improvement activities. These directly support the interpretation and implementation of the Standards, such as fact sheets, toolkits, guides position statements and bespoke responses to direct inquiries. There are also resources regarding practice management, the Medicare Benefits Schedule, emergency response and how it is relevant to members and their practices. The RACGP writes a range of clinical guidelines which are based on best practice evidence. These supports are accessible via the RACGP website.

Awareness of these resources by the general practice profession and their teams seems inconsistent. Due to the nature of the RACGP's traditional relationship to the sector, with individual clinicians being members, it is common that the other members of the practice team are unaware of the support available to them. The RACGP is undertaking a consolidation of communication channels and is seeking to make improvements to the awareness of the work the RACGP undertakes and produces to improve outcomes in general practice.

The accreditation agencies provide a range of resources to practices utilising them to undertake their accreditation assessment. There is limited public information on the resources made available by the accreditation agencies. So, the RACGP has no visibility of the resources provided within a candidate practice's online portal.

There is a potential conflict with the accreditation agencies supporting candidate practices with their accreditation preparation and self-assessment. It is important to understand the process each agency has for this dual role to remove bias from an assessment process.

Primary Health Networks are well-placed, well-connected and funded to maintain or increase the accreditation status of general practices in their regions. In many cases there is a knowledge base of Primary Health Network staff who have undertaken such a role through the Divisions of General Practice and the Medicare Locals to now.

Primary Health Networks have undertaken this work to varying degrees and with varying success. The challenge to providing intensive accreditation preparation support to rural and remote general practices by the Primary Health Networks cannot be understated. The RACGP supports an increased funding schedule to be established for payments to Primary Health Networks to provide intensive support to accredited practices. Such a schedule would need to be explicit in how the funding is to be utilised (specific human resource expectations) and the deliverables that the funding seeks to achieve.

Further support could be provided to the practice manager and other administrative roles. Greater recognition is needed for the significant responsibilities and specialised knowledge required from the general practice team, including compliance to all legislative obligations.

There are options available for formal qualifications, but awareness is currently not promoted and utilised. There are also the practical and financial considerations with most general practice businesses not able to allocate the time, or the financial investment, for members of the practice team to undertake such professional development.

Section: Training standards - Benefits of, and barriers to, training accreditation

21. What are the benefits of, and barriers to, training accreditation?

The process of training accreditation provides a framework which aims to ensure a high-quality learning environment which is safe for both general practitioners in training (GPIT) and patients. The Australian Medical Council provides overarching standards outlining requirements of specialist medical training in Australia. The RACGP Standards for General Practice training (3rd edition) provide the context for this training within the general practice environment. These standards enable a focus of the best processes to ensure that GPs who complete the training program can practice unsupervised anywhere in Australia and meet the highest quality and safety expected by the Australian community.

Whilst training is undertaken in quality practices accredited through the practice accreditation processes, training accreditation against standards focuses on establishment of a supportive learning environment. The benefits of training accreditation include (but are not limited to):

- Outcomes focussed Indicators provide guidance but enable flexibility for application in all general practice settings
- Provides the structure to ensure supervisors are aware of the GP training curriculum and program
- Supports the relationship between the practice and the GPiT through outlining requirements and expectations of the program
- Oversees establishment of supervision systems and processes that support the quality and safety of care provided
- Provides a framework to monitor compliance
- Defines role and responsibilities in supporting the GPiT
- Enables an understanding of practice scope and suitability for different levels of GPiT to support placement
- Builds in opportunities for feedback and assessment
- Provides the practice with opportunities to develop a learning environment whilst meeting workforce needs
- Establishes a focus on cultural safety and education.

Barriers to training accreditation may include:

- Supervisor time away from patient care can be seen as not adequately remunerated
- The current training standards require that the general practice training post is accredited to the current RACGPs Standards for general practices. Any unnecessary administrative burden including duplication of requirements is likely to deter practices from becoming a training practice. Increasing complexity and requirements on general practices through the practice standards could potentially adversely impact upon the capacity of the practice to participate in training. This could impact workforce capacity.
- Commitment to additional supervisor training
- Practice time required to participate in the placement process with no guarantee of having a GPiT placed
- Concerns regarding quality of patient care provided by GPiT
- Complexity of the process.

Section: Training Standards – Key issues

22. What are the strengths and limitations of the current approach to training accreditation through the AGPT Program?

Evaluation of the quality of training is directly accountable to the Medical Board of Australia through the Australian Medical Council in accordance with the legislative requirement under National Health Law. Under National Law, the training provider is responsible for collecting and providing information to training accreditation authorities.

Training practice accreditation is closely linked to general practice training provider and training requirements as documented in the Standards for General Practice Training (Standard 1.3). This link enables training providers to ensure that GPs in training receive a safe and quality training experience.

Training standards are applied to training organisations who are accredited by the RACGP. Regional training organisations, in turn, accredit training sites and supervisors flowing from these standards.

The number of practices requiring training practice accreditation is small when compared to the overall number of practices requiring general practice accreditation. The current system ensures that training accreditation focuses on education and training. The regional approach enables focus on the local context, individualised understanding of areas of need and establishment of relationships and rapport with sites and supervisors.

The relationship developed through training accreditation provides the structure to ensure suitable placement of GPiTs matched to supervisors as well as ability to monitor compliance with expectations and requirements. Supervisors and practice managers are supported through appropriate systems and education.

Training organisations utilise quality improvement, research and evaluation to monitor systems against the standards to better support GPiTs in training.

The current training accreditation approach varies across training organisations with different systems and expectations utilised. Dependent on the training organisation, accreditation systems and documentation requirements may duplicate aspects of practice accreditation.

Variances in the application of the training standards also poses a challenge and could potentially create discrepancy in the levels of training quality received by GPiT across the nation.

23. How could the approach to training accreditation through the AGPT Program be improved under the transition to College-led training and accreditation to:

- ensure clarity of purpose, roles and responsibilities
- improve consistency of assessment and drive confidence in training accreditation reduce duplication between requirements and accreditation processes
- reduce conflicts between the placement of registrars based on workforce need and accreditation
- use learner feedback to inform accreditation decisions and continuous improvement
- ensure training posts are best able to support learners and provide a quality training environment?

The RACGP has developed a training accreditation proposal to be implemented following transition to college-let training. This strategy addresses many of the points above. The RACGP is also working with ACRRM to ensure that accreditation processes are aligned and reduce duplication.

Aspects of the strategy include:

- Development of RACGP Accreditation Standards for Sites and supervisors flowing from the 3rd edition training standards and consistent with Australian Health Ministers' Advisory Council (AHMAC) agreed standards. The Standards for training will be essentially the same, although applied in a direct accreditation context

- Direct relationships between the RACGP and the training practices under profession-led training (PLT)
- Consistent application of accreditation nationally with common systems, assessor training and national evaluation and oversight
- Development of bi-college (RACGP and ACCRM) accreditation guidance and expectations for sites and supervisors
- Working with the RACGP practice standards team to consider development of an additional module covering eligibility for training accreditation with the direct aim of reducing duplication and utilising the practice visit to cover some key aspects. This will require collaboration with the agencies to facilitate information sharing
- Alignment of training reaccreditation dates to practice reaccreditation dates to enable above
- Bi-college (RACGP and ACCRM) agreement on role definitions
- Consideration of workforce need through initiatives to recruit practices in areas of need and planned transparent eligibility criteria
- Support for and ongoing monitoring and evaluation (including feedback mechanisms) of accreditation cycle to foster dynamic learning environments and quality and safe patient care.

There is opportunity to reduce conflicts between workforce and training accreditation through:

- case management of registrars during their career journey
- ensuring registrars are properly supported during their (rural) placement
- appropriate selection of registrars.

24. Describe any opportunities to combine certain aspects of general practice accreditation and training accreditation to reduce the burden on general practices and improve the experience for supervisors and learners

The outcomes of general practice accreditation and training practice accreditation are quite different and, as such, require different types of evidence. However, there are data collection aspects which are common and could be streamlined to reduce duplication of effort and administrative burden.

As above, within the PLT accreditation strategy, the RACGP will work across college to utilise the practice accreditation documentation and practice visit to meet demographic and prescribed aspects of training accreditation.

Following consent, information sharing from accreditation agencies and ACRRM will reduce burden on sites and supervisors. Based on this information, training accreditation will progress to develop a greater college/practice relationship and rapport. This will include:

- Supervisor and practice manager education and roles clarification
- Understanding and agreement of expectations of the training program and GPiT employment
- College consideration of the practice and supervisor and scope of practice
- Personalised local medical educator visits to directly address queries and identify needs and provide support
- Establishment of a relationship which will enable ongoing support and monitoring of compliance.

Reaccreditation will be based on continuous monitoring and/or periodic assessment over the accreditation cycle, feedback and agency practice accreditation confirmation and transfer of collected information. The RACGP will analyse the results of conformance, combined with accreditation agency and practice feedback, to inform refinements and improvements to the accreditation process.

25. For general practices that are accredited for training: Please describe the:

    a) direct costs involved in seeking accreditation (e.g. registration fees, travel and accommodation costs for on site assessment, etc.)

    b) indirect costs in seeking accreditation (e.g. costs of staff time preparing for accreditation, establishing systems and processes to meet the training standards, preparing evidence to demonstrate conformance with the training standards, etc.)

This question is not within the purview of the RACGP to provide a response.

Appendix 1

Literature review: Modernising accreditation

Evidence review

1.1 Topics used for literature search

The following key words were used to search four key academic databases – PubMed, Proquest, EBSCOHost and Cochrane Library:

Accreditation [Mesh term search] OR Unannounced accreditation OR Short notice accreditation OR Announced accreditation OR Standard notice accreditation

The database search was conducted on the 15 January 2020. Searches were limited to journal articles from the last 10 years that were in English.

The review focused on all healthcare accreditation programs. The review identified current evidence from Australia, The Netherlands, Denmark, UK, Canada, New Zealand and USA.

To identify accreditation organisations who conduct primary care accreditation websites were searched using the following search terms:

*accreditat*AND (primary care) AND (standard OR process OR outcome) AND (UK, OR Netherlands, OR Denmark, OR United States, OR Canada, OR New Zealand)*

1.2 Literature review themes (2010-present)

The findings from the evidence search (2010-present) focused on the following themes that are detailed in the next section:

- duration of accreditation cycles
- methods of accreditation (including benefits and limitations)
- models of accreditation surveillance (including benefits and limitations)
- accreditation surveyor perceptions of accreditation and the reliability of their assessments
- overall impact of accreditation on the quality of healthcare
- person centred care and accreditation.

1.2.1 Primary care accreditation

A number (n=6) of literature reviews focused on primary care accreditation programs have identified little research uptake in the primary healthcare systems and on the ways that accreditation may affect healthcare outcomes, quality improvement, perceptions, healthcare utilization and costs. [1, 2]

1.2.2 Duration of primary care accreditation cycles

Table 1 outlines the accreditation method and duration of accreditation cycles for six international primary care accreditation programs. The duration of accreditation cycles varies between three to five years. Canada, New Zealand, the Netherlands and the USA require primary care practices to submit yearly progress reviews on quality improvement plans to maintain accreditation.

1.2.3 Methods of primary care accreditation

Canada

Canadian accreditation uses a tracer methodology to support the accreditation process. It is an interactive process based on direct observation, tracking the movement of a person (for instance, a patient or employee) or an item (material, equipment) through a propriety process from beginning to end. There are two types of tracers used: clinical tracers (evaluates direct patient care) and administrative tracers (assesses organisation's governance, leadership and management). [3] Tracers can be in person or virtual.

Benefits/Limitations

A strength of the methodology as reported by surveyors, were that it is collecting useful, credible and reliable information to assess compliance with Qmentum program standards and priority processes. The results show good coherence between methodology components (appropriateness of the priority processes evaluated, activities to evaluate a tracer, etc). [3]

Limitations that have been reported about this methodology by surveyors in Bouchard et al study include time constraints, medical staff's knowledge involved in the assessment and collaboration. [3] Given its complexity, surveyors do not have time to gain an understanding of an organisation's planning and service design and so rely on what the organisation tells them impacting on the reliability of the evaluation for this process. Additionally, the evaluation is limited to an interview and makes it difficult for the tracer to validate the information obtained.

Denmark

In 2016 a mandatory accreditation scheme was initiated in Denmark. Accreditation status is awarded for a period of three years and eight weeks. This allows for a three year survey cycle, with no gap between expiration of current status and award of a new status. [4]

Accreditation consists of a survey that assesses compliance with minimal requirements and to identify opportunities for improvement, even when the threshold for obtaining accreditation has been reached. A general practice needs to comply with the minimal requirements in order to obtain accreditation. The survey also gives the practice feedback on their efforts to meet the purpose of the standards, and aims to inspire and support quality improvement work.

Surveys are announced well ahead of the planned time. By special agreement, Institute for Quality and Accreditation in Healthcare (IKAS) can provide unannounced surveys as part of an accreditation programme.

After completion of the survey, the surveyor team submits a report to IKAS. IKAS provides a quality check of the report, which includes checking ratings for consistency with the principles and similar previous situations. The surveyor team makes recommendations on follow up, if indicators are Partially Met or Not Met, but it does not make any recommendations on award of accreditation status.

The general practice has an opportunity to review the report and to object to any factual inaccuracies, before it is forwarded to the Accreditation Award Committee, who will decide on the award of accreditation status. The decision about award of accreditation status is made by the Accreditation Award Committee, an impartial authority detached from IKAS and the Board of IKAS in the exercise of its activities. The committee ensures fair and equal treatment of clients, according to clear and transparent rules.

The accreditation status for each client is published on IKAS´ website, separately for each accreditation programme. For some, but not all, programmes, the full survey report is also published.

Benefits/Limitations

Kousgaard et al investigated how GPs and their staff experienced the impact of a mandatory accreditation program in Denmark.[5] The study identified substantial variations in the impact of accreditation. Some practices only implemented minor changes in response to accreditation, some had made a relatively moderate number of changes and a few clinics had made many changes. Most of the specific changes in the clinics concerned changes areas concerning: procedures for following up on para-clinical test results, secure identification of patients, emergency response, hygiene, storage and control of medicine and vaccines, data security and discretion.

The extra work related to accreditation was emphasised as a problem by a majority of the respondents, and in a few cases the prospect of an external control visit was a stress-factor that had impacted job-satisfaction negatively.

The Netherlands

In the Netherlands, primary care practice accreditation is a voluntary activity comprising a comprehensive audit followed by structured planning of improvements and formal review by an external assessor. (6) The intervention consists of a workbook, a supporting website and the obligation to contract a trained consultant to assist the practice through all steps of the program.

Feedback is provided to practices as part of the audit which consists of a comparison with benchmarks of other primary care practices. These benchmarks are discussed during an onsite visit with a trained observer in a feedback consultation with the whole practice team and helps to identify substandard performance domains.

The practice then must plan improvements according to the principles of quality management which is based off the audit feedback. Participants who perform the procedure as planned are all accredited, so accreditation does not imply that a certain minimum score on performance indicators has been obtained.

Every year the practice will be audited and every year new improvement plans have to be formulated which have to be approved by the auditor.

Benefits/Limitations

Nouwens et al identified positive and negative factors that impacted on the accreditation program in the Netherlands.(6)

Factors that were positive regarding accreditation included:

- the adaptability of the program to tailor to the needs of the organisation
- the program provided tools to work systematically
- practice accreditation program participants were obliged to conduct a patient satisfaction survey. Based on these outcomes several participants defined the aims of their improvement plans so that the needs of patients could be met
- participants experienced implementation of the program as more effective when all members of the team were involved and processes were structurally evaluated in team meetings
- an annual visit was for most participants an important motivator for continuous quality improvement and to keep implementation of improvement plans on the practice agenda
- the practice accreditation program had positive effects on team climate and caused more sense of responsibility for quality of care among all team members.

The negatively perceived factors that were found included:

- experiences with the assistance of the consultant varied
- there was a lack of consistency in assessment methods of assessors which caused confusion on how to interpret and execute the program
- all respondents expressed their dissatisfaction with the high costs of the intervention
- audit and feedback is a crucial element of the accreditation program, however choices for improvement plans were rarely based on feedback reports.

New Zealand

A new Accreditation Model for primary care will be introduced in New Zealand from 1 April 2020. (7) To meet Primary Health Organisation Service Agreement Amendment Protocol requirements and qualify for capitation funding, practices need to complete the Royal New Zealand College of General Practitioners (the College) new Foundation programme.

Foundation accreditation is valid for three years. The Foundation Standard outlines the legal, professional and regulatory requirements for general practice. The Foundation Standard has an online assessment tool to upload evidence. Each year a practice submits a reflective assessment confirming they still meet the programme requirements.

In addition to the Foundation Standard practices have an option to choose a level of accreditation: bronze, silver and gold. There are two mandatory quality modules, equity and continuous quality improvement which equate to a 'bronze level' accreditation. The Silver level cornerstone entails practices to complete two core modules plus several elective modules. The Gold level cornerstone entails practices to complete two core modules plus multiple elective modules.

Each Cornerstone module will have a three-year life from achievement. At the end of the third year, the practice will complete a 'refresher' to maintain achievement of the applicable module. The College sends practices a new Cornerstone certificate annually to reflect their current status and the modules that have been achieved and/or maintained in the year.

The College will train and moderate assessors for the cornerstone assessment process, and practices and Primary Health Organisations will manage the assessor visits themselves. The Cornerstone assessment will not be run by the College.

Benefits/Limitations

This model is yet to be implemented therefore information on the benefits and limitations are not available.

UK

Primary care accreditation is voluntary and there is no universal system of accreditation of the quality of organisational aspects of care and no contractual levers to promote organisational quality beyond the voluntary indicators within the Quality and Outcomes Framework (QOF) organisational domain. [8, 9] There are two accreditation schemes that are run in the UK.[10]

- Quality Practice Award: incorporates clinical issues and patient experience and includes a face to face site assessment of paper-based evidence. It is valid for 5 years.
- Practice Accreditation: Introduced in 2011. Has 78 criteria in six domains all focused on organisational issues and includes a mixture of quality assurance and quality improvement criteria. All data are uploaded onto an online web tool and assessed remotely. Accreditation is valid for 3 years.

The Royal College of General Practitioners (RCGP) run a Quality Improvement program for practices however there is no accreditation required against this.[11, 12]

Benefits/Limitations

In 2008, an accreditation scheme called Primary Medical Care Provider Accreditation (PMCPA), focusing on organisational issues of primary care, was developed and piloted in conjunction with the Royal College of General Practitioners (RCGP).[8]

All practices felt that PMCPA was relevant to and aligned with family practice priorities, reflected quality in primary care, and was a worthwhile use of practice time. PMCPA was seen as promoting improvements in organisational standards.

The main risk identified was that externally imposed standards could be seen as a 'tick-box' exercise, with organisations seeking to meet the target without necessarily reflecting on how the issues contained within the standard affect their own setting. It was identified that the practice managers carried out 90–95% of the actual workload and that they, along with doctors, felt that the scheme was too heavily populated by criteria where the evidence for external assessment focused on demonstrating the existence of a protocol or procedure. They felt the PMCPA should focus more on the evidence of implementation and learning rather than the simple presence of a written protocol and the change of benefit to the practice, rather than the simple presence of a written protocol.

USA

Primary care accreditation is voluntary in the USA. Those primary care practices who wish to received patient centred medical home accreditation must enrol via and online system. [13]

The process of accreditation is similar to that in Australia. A practice conducts a pre-assessment prior to the commencement of the accreditation process. A site visit and review of documentation is conducted as well during this process. Following the pre-assessment and initial survey is carried out and reflects upon the requirements of the Patient Centred Medical Home Standards. The initial survey involves an on-site visit where the self-evaluation, relevant documentation and interviews are conducted and reviewed. The surveyor then submits a formal report to a committee who deem the accreditation award.

Accreditation is held for three years with annual surveillance assessments to check the fulfilment of the requirements for maintenance of accreditation. Accredited practices are also listed publically on the National Committee for Quality Assurance (NCQA) webpage.

Benefits/Limitations

There were no current studies, investigating the benefits or limitations of accreditation in primary care in the US, identified in this literature review.

1.2.4 Models of accreditation surveillance

Unannounced vs announced accreditation surveys

Four papers were identified in the literature that focused on the use of unannounced accreditation survey visits versus announced survey visits. [14-17] One paper based in Demark hospital setting, [14] one based in the Netherlands in a nursing home setting [16] and the other two based in Australia. [15, 17] One paper compared unannounced visits in hospitals and general practices whereas the other focused on only the hospital setting.

Ehlers et al evaluated the effectiveness of unannounced versus announced surveys in detecting non-compliance with accreditation standards in Danish public hospitals. [14] Results indicated that the intervention group had 0.6 percentage points fewer consistently implemented standards than did the control group, but the result was not statistically significant. Unannounced hospital surveys were not more effective than announced surveys in detecting quality problems in Danish hospitals. While no significant differences between the intervention and control groups were identified, unannounced surveys were perceived positively by healthcare professionals.

In contrast, Greenfield et al study that conducted unannounced accreditation survey visits in hospitals and general practice identified that the short notice survey approach produced lower assessments than the advanced notification. [15] The use of unannounced surveys assessed clinical issues lower than administrative or corporate issues. Out of the seven general practices included in this study four had been assessed by advanced notification survey and not awarded accreditation status. Similar to Ehlers et al surveyors and staff from the participating organizations stated that short notice surveys should be used by accreditation agencies to replace advanced notification survey visits. The majority of respondents to the ACHS short notice survey trial considered that short notice surveys should be a substitute for periodic review but not for the full organization-wide survey. [15]

Likewise, in Uren et al there was a statistically significant stakeholder opinion that Short-Notice Survey Accreditation Assessment Process (SNAAP) more effectively identified the true strengths and achievements of the organisation's QS compared with 'standard-notice' survey. [17] There was a significantly lower overall perceived proportion of staff resources required for SNAAP preparation in contrast to 'standard-notice' process. The questionnaire results reflected that SNAAP increased staff engagement in quality and safety activities. The survey process was embedded within a change management program and the hospitals had been successful in gaining previous accreditation.

Klerks et al conducted an exploratory study that aimed to see if inspectors detect similar risks during an unannounced, and an announced, inspection of the same nursing home facility. [17] The results showed a small, though not significant, difference in how the risk factors were assessed during the unannounced inspections compared to the announced ones. During the unannounced inspections, the inspectors assessed, on average, slightly more than 10% fewer risk factors than during the announced inspections. The choice of performing an unannounced inspection first, followed by an announced inspection, later, can influence the results of the announced inspection.

Digitisation of accreditation

Two papers were identified in the literature review that focused on digital or electronic tools for accreditation purposes. [18, 19] One based in an Australian hospital setting and the other in Tanzanian out-patient departments.

Barnett et al outlined a case study where data analyst researchers in a digital quaternary hospital designed a system to collect information regarding the 10 national quality and safety standards in real time. [18] It was key that clinicians had true clinical ownership of the process and validated their own data and created their own data views. Upskilling staff in digital literacy and establishing endorsed workflows was also important to the success of the new system. The system was used during a reaccreditation process which was successful. The national standard dashboards enabled the index hospital to interrogate clinical data in real time in response to surveyor queries.

Renggli et al analysed an electronic tool, which was developed to assess and monitor the quality of healthcare (dispensaries, hospitals) in Tanzania in the context of routine supportive supervision. [19] The assessment methods included checklists, structured interviews and clinical observations in order to assess processes and structural key indicators primarily focusing on adequacy. The study identified factors not directly related to quality of care (number of indicators assessed and average of answers given per indicator) could influence the assessment results. Addressing these factors would make the assessment technically more demanding, time-consuming and expensive. In practice, its ability to measure quality of care over time reflected a feasible approach during supportive supervision and received great support from the health facilities staff. Unfortunately, due to its design and purpose the electronic Healthcare assessment tool in its current format is unlikely to be accurate enough for higher level of care, licensing or accreditation as well as providing evidence for national policy, planning or management decisions.

1.2.5 Accreditation surveyors

Accreditation surveyor's perceptions of accreditation

There is limited research on accreditation surveyor's perceptions of accreditation. The limited literature has investigated the perception and experiences of accreditation surveyors on the impact of accreditation on quality and safety,[20-22] as well as, the benefits of being an accreditation surveyor. [23] The literature identified that most participants agreed that accreditation has improved performance in quality and safety. Although, there were also barriers that they encountered, such as, an increase in the amount of documentation surveyors are required to review and what constitutes sufficient evidence for certain aspects of accreditation such as clinical risk management.[20, 22] Doubts were also expressed about accreditation and its impact on improved practice performance, such as the "one-off" nature of accreditation and sustainability of improvement efforts.[20] It was suggested that the data be reviewed in an ongoing review rather than a cyclical process.[22] dos Santos et al described some limitations in training opportunities for surveyors in Canada, although, this was not reported as an issue in the other three Australian studies where it was felt surveyors were sufficient trained. [20, 21, 22]

Lancaster et al investigated surveying benefits to accreditation surveyors. [23] The study found that accreditation exposes the surveyor to new methods and innovations, provides a unique form of ongoing learning, provides opportunities to contribute to the process of quality improvement and serves as a way for acquiring expertise to enhance quality within the organisations they were regularly employed.

Reliability of accreditation surveyors

The reliability of accreditation surveyors to conduct hospital accreditation has been investigated in Australia [24, 25], the Netherlands [26] and the UK [27]. High inter-rater reliability among accreditation surveyors was found particularly when there were surveyor groups or teams involved in the survey [24-27] and where discussions or consensus meetings between surveyors occurred [26, 27]. Interestingly, having a mix of different professions in inspection teams did not appear to affect reliability. [27]

Greenfield et al also highlighted that surveyor reliability was informed by the management of the accreditation process, including standards and health care organizational issues; surveyor workforce management and the survey coordinator role. [15]

1.2.6 Impact of accreditation on the quality of care

The impact or value of accreditation on hospitals has been investigated widely within the literature. Reviews of the literature have provided substantial insight into the inconsistent approaches applied by studies looking at the impact of accreditation, therefore impacting effective conclusions from the reviews. [28-33] Nevertheless, we have summarised the main outcomes under four headings: staff attitudes towards accreditation, accreditation impact on patient related outcomes, impact on organisational change and longitudinal effect of accreditation over time.

Staff attitudes towards accreditation

Previous research has found that some staff value accreditation for creating organisational foundations for future quality improvement initiatives [34], for enhancing standardised processes [28] and clarifying responsibilities in the organization.[35] While others perceived it as detracting from patient care due to increased time spent on working on documentation,[34-36] creating high stress before and during the survey visits,[37, 38] as well as, being reported as a costly process [36, 39-41]. In Australia, hospital accreditation costs around 0.1% of the acute public hospital budget.[38]

Impact on patient related outcomes

Current evidence has identified that accreditation has an impact on patient related outcomes.[28, 42-47] For example, patients at fully accredited hospitals had a significantly higher probability of receiving care according to clinical guideline recommendations than patients at partially accredited hospitals across conditions.[42] The 30-day mortality risk for in-patients admitted at accredited hospitals decreased [43, 44] and patients admitted to hospital had a lower risk of dying within 30-days after admission than in-patients at partially accredited hospitals. [45] Interestingly, Barnett et al study highlighted that patients admitted to hospitals during accreditation survey weeks have significantly lower mortality than during non-survey weeks, particularly in major teaching hospitals. Infection control performance was also positively associated with accredited facilities. [44]

In contrast, Lam et al study found no meaningful association between accreditation and mortality rates in US hospitals. [46] The study noted lower readmission rates for the 15 selected medical conditions in accredited hospitals however the differences were modest [46] This results was echoed in Litchman et al study that found a limited positive association favouring accredited facilities.[47]

Impact on organisational culture

Accreditation has seen a positive impact on organisation culture within healthcare organisations. Accreditation has seen a positive impact on clinical leadership, [48-51] a shift from hierarchical culture to group culture,[48, 52, 53] improved staff engagement [50, 53] and improved quality systems to manage patient care. [28, 49-51]

Longitudinal effect of accreditation over time

The longitudinal effect of accreditation on hospital performance over time was investigated by two recent studies.[54, 55] One study identified ongoing improvement in continuity of quality patient care in accredited hospitals,[54] while the other saw a slide in performance over time.[55] The current, limited evidence is conflicting and makes it difficult to conclude on the overall longitudinal effect of accreditation on hospital performance.

1.2.7 Person centred care and accreditation

A previous literature review conducted by the Standards Business Unit focuses on the use of patient experience surveys as a common form of understanding patient experiences and satisfaction with a health organisation.

Some limited literature was identified in this review that focused on other ways patients/consumers can be encouraged accreditation. In the US there is a Person-Centered Care Certification Programme that health organisations can undertake in order to improve patient experience and patient loyalty. [56] A recent Australian study [57] has investigated how consumer engagement (CE) can be promoted through Australian accreditation programmes.

1.3 Summary of key findings

A summary of key findings include:

- there has been little research uptake in the primary healthcare systems and on the ways that accreditation may affect healthcare outcomes, quality improvement, perceptions, healthcare utilization and costs
- although current evidence of unannounced accreditation surveys does not provide significant evidence for accreditation surveys to change to this format, there has been positive feedback from participants regarding the methodology
- there is limited evidence surrounding the digitisation of accreditation however there may be further emerging studies in the coming years following on the experience with COVID-19 and adapting accreditation methods
- accreditation survey reliability is improved with accreditation teams and when surveyors can discuss the survey outcome
- there are mixed attitudes towards accreditation with studies highlighting that increased documentation and cost as being a key barrier to the accreditation process
- there are positive organisation impacts of accreditation
- the current, limited evidence is conflicting and makes it difficult to conclude on the overall longitudinal effect of accreditation on hospital performance.

Table 1. International comparison of primary care accreditation

Country	Accreditation Model	Length of accreditation
Canada	The Qmentum program, consists of a four-year cycle conducted in four phases. • Self-assessment: Provides a snapshot of the extent to which an organization meets the standards. Areas requiring more in-depth assessment are identified, and an order of priority is established for sectors requiring follow-up. • On-site survey: Utilises a tracer methodology, an interactive process based on direct observation, tracking the movement of a person or an item through a priority process from beginning to end. What happens in the process is compared with Accreditation Canada's compliance criteria. There are eight steps: 1. Review the priority process 2. Identify documents needed 3. Review charts and files 4. List people and places that need to be seen 5. Determine questions to ask 6. Discuss findings with team during surveyors' information exchange 7. Rate criteria 8. Write comments for the organization • **Accreditation decision:** Once the survey is over, Accreditation Canada makes one of three possible decisions: accreditation, accreditation with conditions and non-accreditation • **Progress review:** Progress is reviewed through indicator data submitted annually and through updates of the action plan	A four-year cycle A progress review is submitted annually. (3, 58)

Denmark	In 2016 a mandatory accreditation scheme was initiated in Denmark. Accreditation consists of: • A survey: To assess compliance with minimal requirements and to identify opportunities for improvement, even when the threshold for obtaining accreditation has been reached. A general practice needs to comply with the minimal requirements in order to obtain accreditation. The survey should also give the client a feedback on his or her efforts to meet the purpose of the standards, and give this in a way that inspires and supports quality improvement work. • A surveyor team consists of healthcare professionals who have received specific training to handle this task. Some surveyors in the practice sectors are IKAS employees, but all survey teams will include surveyor(s) who are peers, working most of their time in healthcare. Compliance assessment is governed by defined rating principles. The fundamentals are the same for all programmes: Met, Largely Met, Partially Met, Not Met • As a rule, surveys are announced well ahead of the planned time. By special agreement, IKAS can provide unannounced surveys as part of an accreditation programme. • After completion of the survey, the surveyor team submits a report to IKAS. • IKAS provides a quality check of the report, which includes checking ratings for consistency with the principles and similar previous situations. The surveyor team makes recommendations on follow up, if indicators are Partially Met or Not Met, but it does not make any recommendations on award of accreditation status. • The general practice has an opportunity to review the report and to object to any factual inaccuracies, before it is forwarded to the Accreditation Award Committee, who will decide on the award of accreditation status. • The decision about award of accreditation status is made by the Accreditation Award Committee, an impartial authority detached from IKAS and the Board of IKAS in the exercise of its activities. The committee ensures fair and equal treatment of clients, according to clear and transparent rules. • The committee will review a random sample of client cases annually to ensure that the process from the survey to the final decision on award, including the rating of indicators, has been fair, unbiased and according to prevailing rules. If any concerns are identified, the committee will make pertinent recommendations to IKAS. • If at the re-assessment all indicators are rated as Met or Largely Met, the Accreditation Award Committee will award the client status as Accredited.	Accreditation status is awarded for a period of three years and eight weeks. This allows for a three-year survey cycle, with no gap between expiration of current status and award of a new status. (4)

	• If there are indicators rated as Partially Met or Not Met, the Accreditation Award Committee will have to decide, whether the clients be awarded status as either Accredited with comments or Not accredited. • The accreditation status for each client is published on IKAS´ website, separately for each accreditation programme. • For some, but not all, programmes, the full survey report is also published. • As IKAS operates according to the rules for public administration, everyone is entitled to request a copy of any survey report from IKAS according to the Danish Open Administration Act.	
New Zealand	**New Accreditation Model for primary care from 1 April 2020** • To meet Primary Health Organisation Service Agreement Amendment Protocol requirements and qualify for capitation funding, practices need to complete the College's new Foundation programme. • The Foundation Standard outlines the legal, professional and regulatory requirements for GP. • The Foundation Standard has an online assessment tool to upload evidence. • In addition to the Foundation Standard practices have an option to choose a level of accreditation: bronze, silver and gold. • There are two mandatory quality modules, equity and continuous quality improvement which equate to a 'bronze level' accreditation. • The Silver level cornerstone entails practices to complete two core modules plus several elective modules • The Gold level cornerstone entails practices to complete two core modules plus multiple elective modules • The Cornerstone assessment process will no longer be run by the College. The College will train and moderate assessors, and practices and PHOs will manage the assessor visits themselves.	• Foundation accreditation is valid for three years. • Each year a practice submits a reflective assessment confirming they still meet the programme requirements. • Each Cornerstone module will have a three-year life from achievement. At the end of the third year, the practice will complete a 'refresher' to maintain achievement of the applicable module. • The College sends practices a new Cornerstone certificate annually to reflect their current status and the modules that have been achieved and/or maintained in the year. (7)
The Netherlands	Voluntary accreditation since 2005 Comprises of: • A comprehensive audit, which covers clinical and organizational domains. • Feedback is provided as part of this audit that which consists of a comparison with benchmarks of other primary care practices, is discussed with a trained observer in a feedback consultation with the whole practice team and helps to identify substandard performance domains. • The practice then must plan improvements according to the principles of quality management which is based off the audit feedback. Participants who perform the	• Participants receive a certification for the time period of one year which demonstrates their involvement in continuous quality improvement. • Every year the practice will be audited and every year new improvement plans have to be formulated which have to be approved by the auditor. • The prolongation of the accreditation depends on having met the objectives of the improvement plans. (6)

	procedure as planned are all accredited, so accreditation does not imply that a certain minimum score on performance indicators has been obtained. • Every year the practice will be audited and every year new improvement plans have to be formulated which have to be approved by the auditor.	
UK	Voluntary accreditation since 2011 There is no universal system of accreditation of the quality of organisational aspects of care and no contractual levers to promote organisational quality beyond the voluntary indicators within the Quality and Outcomes Framework (QOF) organisational domain. Two accreditation schemes: • QPA: incorporates clinical issues and patient experience and includes a face to face site assessment of paper-based evidence. It is valid for 5 years. • PA: Introduced in 2011. Has 78 criteria in six domains all focused on organisational issues and includes a mixture of quality assurance and quality improvement criteria. All data are uploaded onto an online web tool and assessed remotely. Accreditation is valid for 3 years.	3 years (PA) or 5 years (QPA) (8, 9)
USA	Voluntary accreditation Patient Centred Medical Home accreditation 1. Application for accreditation: practices enrol via Q-PASS prior to the date they want recognition. 2. Pre-assessment: prior to commencement of accreditation/ certification process. Consists of a document review and site visit. 3. Initial Survey: Carry out survey against the requirements of the Patient Centred Medical Home Standards by verifying the fulfilment of requirements or professional competence as well as the efficiency of the management system. Involves an on-site visit where the self-evaluation, relevant documentation and interviews are conducted and reviewed. 4. Accreditation Award: surveyors submit formal report to a committee who deem the accreditation award. 5. Maintaining accreditation: annual surveillance. Optional for practices to apply for distinction in behavioural health integrational accreditation.	3 year accreditation cycle. (59) Annual surveillance assessments to check the fulfilment of the requirements for maintenance of accreditation.

	Accredited practices are listed publically on the NCQA webpage.	

Review conducted February 2020

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