

Australian General Practice Network's submission to the Australian Commission on Safety and Quality in Health Care's *Practice-level indicators of safety and quality for primary health care* consultation paper

October 2011

Introduction

The Australian General Practice Network (AGPN) welcomes the opportunity to provide comment on the Australian Commission on Safety and Quality in Health Care's (the Commission) *Practice-level indicators of safety and quality for primary health care* consultation paper.

AGPN supports, in principle, the concept of developing a set of practice-level indicators for primary health care (PHC) practices which can be voluntarily adopted as an aid to implementing practice improvement strategies and policies. AGPN has consulted with its Network members on the Commission's consultation paper and provides comment on the associated areas below.

About AGPN

AGPN is the peak national body representing general practice networks and state based entities across Australia. More than 90 percent of general practitioners (GPs) and an increasing number of practice nurses and allied health professionals are members of their local general practice network. The Network is involved in a wide range of activities focused on improving the health of the Australian community including health promotion, early intervention and prevention strategies, data and information management, health service development, chronic disease management, medical education and workforce support.

The Network is currently in transition, providing the foundation for the establishment of the new national Medicare Locals (MLs) Network. The Australian Government has invited AGPN to form the national body for the National MLs Network. If successful in its application, it is expected that AGPN will have transitioned to this new role by early 2012 and, as the ML national body, will be providing leadership and support to MLs in driving change management at a regional level and driving high quality primary health care performance across the country.

General comment on the candidate-set of indicators

- a) AGPN agrees with the Commission's intention to make the indicators flexible enough to allow for local adaptation and setting-specific relevance, and we recognise that their principal purpose is not for cross-practice performance comparability. However, our general view is that many are too ambiguous and subjective which:
1. risk the indicators losing meaning and value as they are interpreted and applied differently over time and;
 2. stymies any opportunity to compare data/results across practices/organisations.

AGPN recommends that all indicators are reviewed in this context, with actions taken to more clearly develop and define the benchmarks for which improvement is being measured against. Creating a level of standardisation across the indicators would improve consistency across settings and allow for greater internal accountability.

- b) AGPN recommends reviewing use of the term "clinician" throughout the indicators. Primary health care is delivered by a vast and diverse range of health professionals, such as community health promotion officers, who would not generally be considered "clinicians" but who will play a role in quality and safety. Use of the term "clinician" throughout the document risks excluding these health professionals from adopting and using the indicators. "Practitioner" may be a more appropriate word given its broader definition.
- c) The indicators appear, in the main, to be mostly focussed on medical practices. We suggest additional indicators are added or that indicators are re-worded to reflect the broader range of primary health care professionals and settings involved in delivering care. These settings should include allied health, pharmacy and community settings in which a variety of community health workers deliver health education, counselling and prevention measures. While it is understood that the indicators are currently proposed to be optional, they are more likely to be taken up if they are relevant to all primary health care settings. If indicators are to be valuable and relevant to the full spectrum of primary health care professionals and settings, allowing for safety and quality improvement within them, the full continuum and scope of primary health care service delivery must be considered when developing the final set of indicators.
- d) The *safety* dimension indicators need to be boosted to incorporate measures associated with a proactive approach to occupational health and safety across a much broader range of areas. As well as a specific 'infection control' indicator, the safety indicators should also cover sharps' use and disposal, medication and vaccine storage, patient/clinical handover processes and general

occupational health and safety matters relevant to practice set-up (eg steps/ramps, lighting, falls prevention etc). Of particular importance would be a measure associated with health professional safety in relation to difficult and/or potentially aggressive patients that covers both in practice as well as out of practice/home visit situations both in and out of normal hours. We would also see value in adding an indicator that relates to patient privacy and health information management.

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

Comment against individual candidate-set indicators

Below we provide comments in red against individual indicators which we believe require further consideration by the Commission in its development of the final set.

Candidate practice-level indicators of safety and quality for primary health

Care Dimension	Candidate indicators	Description	#
Accessibility	First contact to service wait time	The proportion of patients whose wait from first contact to first service is within the locally agreed timeframe	1
	First contact to service wait time for high-priority patients	The proportion of patients who are high priority according to locally agreed criteria, and whose wait from first contact to first service is within the locally agreed timeframe	2
	Eligible patients who received a service	The proportion of eligible patients requesting a service who received a service	3
	Non-attendance at booked service	The proportion of patients who did not attend a booked service	4
Appropriateness	Health summary	The proportion of regular patients with a comprehensive health summary, including information on allergies, current/past medical history, medications and risk factors, which was updated within the previous 12 months	5
	Patient assessment	The proportion of patients assessed, using a validated assessment tool appropriate to the scope of the practice and patient's needs	6
	Timely initial needs identification	The proportion of patients whose initial needs identification was conducted, within the locally agreed timeframe	7
	Complete care plan	The proportion of patients with multiple or complex needs who have a complete care plan <i>Suggest that a standard definition of "multiple/complex needs" be used</i>	8
	Recalls and reminders	The proportion of patients with a complete care plan who were given recalls or reminders as recommended in the care plan	9
	Adherence to clinical guidelines	The proportion of patients with complete care plans that are in accordance with agreed clinical guidelines	10

	Timely review of care plan	The proportion of patients with a recorded care plan that is reviewed by the planned review date	11
	Medication review	The proportion of regular patients whose medication list was reviewed by a clinician within the previous 12 months	12
	Interpreter services	The proportion of patients who indicated their need for an interpreter and who were provided with interpreter services at the first service This needs to more clearly reflect patients who require different types of communication assistance, e.g. deaf, mentally impaired etc. At the moment it implies assistance only with foreign language.	13
	Aboriginal and Torres Strait Islander awareness/sensitivity	The proportion of Aboriginal and Torres Strait Islander patients who have received communications that are culturally appropriate What is "culturally appropriate"? This needs to be defined through the use of standardised guidelines/framework.	14
	Cultural and linguistic diversity awareness/sensitivity	The proportion of patients who have received communications that are culturally and linguistically appropriate Suggest this indicator becomes a more general indicator about clear and culturally/linguistically appropriate communication that can then be referred to in indicator 21.	15
Acceptability/patient participation	Self-rated health	The proportion of regular patients who have completed a validated self-rated health status instrument that informs their individual care and service improvement	16
	Patient experience survey	The proportion of regular patients who have been given the patient experience survey within the previous 12 months (using a standard patient experience instrument) to inform more general improvements in the type of care provided by the practice. AGPN has recently piloted a patient experience survey instrument through the General Practice Network. Reports on these pilots are currently being collated. It is important – as argued in regard to other indicators – that standardisation in measurement of indicators is achieved where possible.	17
	Patient experience survey response rate	The proportion of regular patients who have provided feedback about their patient experience within the previous 12 months (using a standard patient experience instrument) See above	18
	Satisfaction with patient experience	The proportion of regular patients who are very satisfied with specified elements of their patient experience within the previous 12 months (using a standard patient experience instrument) See above	19
	Patient complaints response	The proportion of patient complaints responded to within the service's nominated timeframe from receipt of complaint	20
	Informed consent for treatment	The proportion of patients (and/or carers) who have had information about the purpose, treatment options, benefits, risks and costs of care discussed with them Unclear how this would this be measured although it could include both a patient and/or clinician survey. Determining "informed consent" can be difficult as signing a consent form does not always equal understanding of the information. However, this becomes less of an issue if the changes proposed above to indicator 15 are made.	21
Effectiveness	Patient improvement	The proportion of regular patients whose condition has improved, measured using a validated tool or clinical guideline (for conditions where improvement is expected, e.g. diabetes, weight reduction, smoking cessation)	22
	Goals of care attainment	The proportion of goals met in the timeframe stated for attainment of each goal for patients with a care plan	23
	Goals of care partially attained	The proportion of goals partially met in the timeframe stated for attainment of each goal, or appropriately renegotiated, for patients with a care plan	24
Coordination of care	Referral process	The proportion of practice referrals that are issued in accordance with the practice's policy for referral processes (for appropriateness and timeliness) This could be extended to include referrals that are received and acted	25

		upon also, although may be better covered in the "accessibility" section.	
	Referral content	The proportion of practice referrals that contained appropriate identifying, clinical and contact information and a current medication list "Appropriate information" needs to be defined and standardised.	26
	Allocation of a 'key contact' person/case manager	The proportion of patients with multiple or complex needs who are allocated a 'key contact person' or care coordinator, and are given their contact details	27
	Timely communication to GP/specialist doctor	The proportion of patients where timely reporting of care assessments or outcomes was communicated to the patient's GP or specialist doctor (1) "Timely" needs to be defined; and (2) Suggest broaden this communication to include more than GP and specialist doctors. Communication of patient assessments and outcomes should occur between all relevant health care team members.	28
Continuity of care	Timely review and follow-up of diagnostic results	The proportion of patients whose diagnostic results were reviewed by a clinician and acted on in a timely manner in accordance with agreed clinical guidelines "Timely" needs to be defined and standardised.	29
	Medication reconciliation	The proportion of patients whose medication list has been reconciled against the service's patient health record	30
Safety	Adverse drug reactions and medication allergies	The proportion of patients whose known adverse drug reactions and medication allergies are documented in the service's patient health record This appears to duplicate indicator 5	31
	Patient safety incidents investigations	The proportion of the service's documented patient safety incidents (i.e. near misses or errors, and adverse events that result in harm) where an investigation has been completed in accordance with local policy	32
	Patient safety incidents follow-up	The proportion of the service's documented patient safety incidents (i.e. near misses or errors, and adverse events that result in harm) where action is taken to reduce risks identified through the investigation	33
	Infection control	The proportion of the service's eligible workforce who have received infection control training within the previous 12 months	34

Existing performance frameworks and indicators

AGPN acknowledges the Commission's comprehensive environmental scan in relation to identifying existing and ongoing work in the field of primary health care performance frameworks and indicator resources. AGPN notes that many of the currently suggested indicators are already present in the existing general practice standards for accreditation and/or as part of the Practice Incentive Payments (PIP) program for general practices which aims to enhance quality care in general practice. We would, however, like to emphasise the importance of developing and ratifying the final set of practice-level indicators in consideration of the vast array of other relevant available resources so that these indicators do not:

- (1) duplicate any existing work causing waste and inefficiencies;
- (2) cause confusion in relation to which indicators should (and in some cases must) be used in preference to other existing sets and;
- (3) contradict any measures or indicators currently in use or being developed such as those associated with general practice accreditation, the National Medicines Policy, Healthy Communities Reports etc.

This will be especially important if the indicators move from voluntary to more mandatory uptake.

Clinical governance

In the consultation paper the Commission notes that, to date, there has been comparatively little clinical governance work undertaken specifically for primary health care (notwithstanding increasing levels of work around general practice). AGPN agrees with this sentiment but would like to bring to the Commission's attention the collaborative clinical governance project that it is currently undertaking with the Centre for Clinical Governance Research in Health at the University of NSW. This project is sourcing, modifying or developing tools, templates and materials to support Medicare Locals in performing their clinical governance in primary care role and is expected to be completed in November 2011.

AGPN brings this to the Commission's attention to alert it to the resources that will be available in due course, and to subsequently ensure duplication does not occur through a separate but similar clinical governance project.

AGPN also suggests that any further work on these indicators includes consideration of the role of the Lead Clinician Groups (LCGs) which are due to be formed as part of the current health reform and which AGPN understands are required to work collaboratively with existing organisations such as the Commission.

The Commission's consultation process

AGPN acknowledges the consultation process undertaken by the Commission and its contractors prior to the release of this public consultation paper, however, AGPN has no record of direct recent consultation on this matter. AGPN and its members have a considerable stake in the development and finalisation of any practice-level indicators for primary care and therefore ask explicitly to be notified in regard to the national forum where the Commission is planning to seek endorsement of the final set of indicators.

AGPN welcomes the opportunity to discuss any positions taken in this submission with you further. To arrange any future discussion or to follow up on any queries regarding this submission, please contact Scott Brown: sbrown@agpn.com.au; 02 6228 0832.