



QAIHC

Queensland Aboriginal and Islander
Health Council



**RACGP Standards
for General Practices
5th Edition**

SUBMISSION

from the Queensland
Aboriginal and Islander
Health Council

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Queensland Aboriginal and Islander
Health Council

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IN-CONFIDENCE

SUBMISSION FROM THE QUEENSLAND ABORIGINAL AND ISLANDER HEALTH COUNCIL

5TH EDITION OF THE RACGP STANDARDS FOR GENERAL PRACTICES
(DRAFT 1 JUNE 2016)

EXECUTIVE SUMMARY:

The Queensland Aboriginal and Islander Health Council (QAIHC) wish to thank the RACGP for the opportunity to comment on the draft 5th Edition of the RACGP Standards for General Practices (the *Standards*). The aim of the 5th Edition of the Standards is to ensure they reflect contemporary practice and enable access to high quality primary health care. The 5th Edition of the Standards has improved from the previous edition. It is well structured and easy to read.

This QAIHC submission refers to the third consultation phase on the Standards. It refers the RACGP to areas where the Standards still need to reflect contemporary practice. QAIHC has provided a number of recommendations with sufficient detail to assist with making changes to the Standards.

This submission has a focus on **two key areas** where the Standards can improve:

- the quality of care, and
- patient and community participation in their care.

The submission refers to:

- The need to improve the responsiveness of all primary care services to Aboriginal and Torres Strait Islander patients;
- Inclusion of the right that patients have to be included in decisions and choices about their care ('participation');
- The need to include reference to strategies to meet the needs of cultural groups;
- Inclusion of the obligation for practices to engage with patients who wish to have information uploaded to the *My Health Record (MyHR)*;
- Improvement in the continuing quality improvement (CQI) activities to reflect the current e-health environment which makes CQI activities more feasible;
- More examples reflective of quality *ongoing* patient feedback mechanisms.

In this submission, we provide examples of how client/patient participation might be demonstrated by general practices and other services and where this can appear in the Standards. This submission refers to:

Module 1: Core Module

- Standard 1: Communication with patients
 - Criterion 1.3- Informed patient decisions
- Standard 2: Rights and responsibilities of patients
 - Criterion 2.1- Respectful and culturally appropriate care
- Standard 6: Continuity of care
 - Criterion 6.2- Clinical handover

Module 2: Quality Improvement Module

- Standard 1: Quality Improvement
 - Criterion 1.2 – Patient Feedback
 - Criterion 1.3- Improving Clinical Care

BACKGROUND

The QAIHC is the peak body representing Aboriginal and Islander Community Controlled Health Services (AICCHS) and Organisations in Queensland and plays a leading role in enhancing the quality of care delivered to Aboriginal and Torres Strait Islander peoples. The goal of improving the quality of care to Aboriginal peoples is why AICCHSs were established over 40 years ago. **That goal was to provide opportunities for Aboriginal peoples to meaningfully participate in the health care system**- opportunities that were historically denied to them in the past.

AICCHSs now form part of a national system of primary health care services that specialize in providing comprehensive and quality care to Aboriginal peoples and Torres Strait Islanders.

All AICCHSs in Qld:

- have comprehensive systems of involvement with and accountability to the local community;
- are currently accredited and have met the RACGP standards for general practices¹;
- undertake local continuing quality improvement (CQI) activities;
- participate in state and national quality improvement programs;
- provide national key performance indicator (nKPI) reports to the Australian Government via the Australian Institute of Health and Welfare;
- utilize electronic health records, and decision-support systems to optimize patient care;
- utilise data extraction tools to prepare reports on performance for quality assurance: report on the health status of patients, profile of patients, travel time for patients, the quality and completeness of patient information, and disseminate practice specific information to members, the local community and other stakeholders;
- participate in state-wide and national performance benchmarking systems.

These activities are more advanced than in other primary care services and aim to enhance patient-centred care and reduce health care disparities with a focus on:

- the quality of care, and
- patient and community participation.

The focus on these two issues is consistent with Australia's priorities for primary health care to move from 'volume' to 'value' services. The Australian Government, the Australian public, and health professionals recognize that our primary health care system needs reform and needs to enhance patient-centredness.²

This reform is being seen in general practice with efforts to enhance use of quality improvement tools [one example is the health systems assessment tool- Practice Care Improvement Tool [PC-PIT)], strategies for consumer involvement in co-design or re-design of health services, and more inclusive strategies for patient feedback from individual encounters through to inclusion in systems of governance within

¹ Australian Institute of Health and Welfare 2016. Aboriginal and Torres Strait Islander health organisations: Online Services Report—key results 2014–15. Aboriginal and Torres Strait Islander health services report No. 7. IHW 168. Canberra: AIHW. Page 7.

² Primary Health Care Advisory Group. Primary Health Care Advisory Group Final Report Better Outcomes for People with Chronic and Complex Health Conditions. Commonwealth of Australia, 2016.

services.³

Consumer/patient participation

The Australian Charter of Health Care Rights⁴ (the 'Charter') developed by the Australian Commission on Health Care Quality and Safety (ACHCSQ) recognizes that patients have a right to receive quality care and to be participants in their own health care. All Australians have a right to be included in decisions and choices about their care. The Charter refers to this important right as 'participation'.

Consumer participation in health care can mean many things. It can mean a patient has merely been 'informed' or provided with information by a health care provider. It can also mean that a patient has been supported to be an active participant in decisions about their treatment, such as being enabled to self-manage the disease or illness that they live with. There is now an international focus on the latter, so that patients are more involved as partners in health care decisions and their participation in shared decision-making is increased.⁵

How can client/patient participation in health care be demonstrated?

The RACGP recognizes that it is a core responsibility for health care providers to involve patients in decisions about their care. The RACGP even adapted the Australian Charter in the 'General Practice Patient Charter'.⁶ However, this commitment is not evident in the 4th Edition, nor in the draft 5th Edition (Feb 2016) of the General Practice Standards.

All ACCHSs and many general practices across Australia can demonstrate client/patient participation in decisions about their health care. This participation can be demonstrated through health care interactions with individual patients as well as the population level. Patient reported experiences from feedback surveys can verify the participatory nature of clinic interactions with individual patients. There are also many ways in which a health service can demonstrate how a community has influenced the quality of care that is delivered.

Aboriginal peoples participation in health care

Aboriginal peoples and Torres Strait Islanders have poorer access to and poorer health outcomes from primary health care services than other Australians.⁷ Aboriginal peoples social exclusion often means they receive inferior care than other Australians.⁸

Aboriginal peoples have fewer opportunities to voice their concerns, and are often disempowered in their interactions with the health care system limiting their ability to engage as partners in decision-making about their care. Lower educational levels,

³ MJA Supplement. Value co-creation: a methodology to drive primary health care reform. MJA 18th April 2016.

⁴ <http://www.safetyandquality.gov.au/national-priorities/charter-of-healthcare-rights/>

⁵ British Medical Journal. Spotlight on patient-centred care, BMJ, 2016. <http://www.bmj.com/patient-spotlight>

⁶ <http://www.racgp.org.au/download/Documents/Tools/The-RACGP-General-practice-patient-charter-implementation-guidelines.pdf>

⁷ National Health Performance Authority. Healthy Communities: Potentially preventable hospitalisations in 2013–14. National Health Performance Authority, Sydney, 2015. <http://www.myhealthycommunities.gov.au/our-reports/potentially-preventable-hospitalisations-december-2015>

⁸ Australian Medical Association. Institutionalised inequity. Not just a matter of money. AMA, Canberra, 2007. <https://ama.com.au/article/2007-ama-indigenous-health-report-card-institutionalised-inequity-not-just-matter-money>

and the disproportionate impact of the social determinants of health compound Aboriginal peoples inability to participate in, and consequently take responsibility for health care decisions.

There is evidence that treatments offered to Aboriginal peoples are influenced by stereotypes about them. A refusal of treatment by an Aboriginal patient may be viewed as 'culturally based' rather than a result of fear, misunderstanding or other preferences never elicited. The high rate of hospital discharge against medical advice (8 times higher in Aboriginal peoples than non -Indigenous Australians) is one example of this phenomenon.⁹

Whilst ACCHSs are exemplar services for client/patient engagement in their health care decisions, all health care providers have a responsibility to enhance Aboriginal peoples participation in decisions about their health care. This submission assists the RACGP to identify how this might be reflected in the Standards.

Focus of this submission

This submission focuses on two issues- quality care and client/patient participation in health care. It makes recommendations on these issues to assist with updating the 5th Edition RACGP standards in line with contemporary practice.

⁹ Australian Health Ministers' Advisory Council, 2015, *Aboriginal and Torres Strait Islander Health Performance Framework 2014 Report*, AHMAC, Canberra.

RECOMMENDATIONS

Module 1: Core Module

Standard 1: Communication with patients

Criterion 1.3- Informed patient decisions

The 4th Edition of the Standards did not include any mention of 'patient participation' or engagement as a requirement for quality service provision. The draft 5th edition of the Standards emphasizes patient participation (see below), but lacks an indicator to demonstrate that commitment.

QAIHC Recommendation:

- Standard 1 be renamed. It should change from 'Communication with patients' to: '*Communication and patient participation*'.
- Criterion 1.3 ('Informed patient decisions') to include Indicators reflecting the commitment to patient participation in order to be consistent with Australia's Charter:
 - Add a new indicator (1.3C):
 - ▶ C. "*Our patients are included in decisions and choices made about their care*".
 - Add a further new indicator (1.3D):
 - ▶ D: "*Our patients are supported to self-manage their disease or illness*".
 - The above new indicators to be mandatory.
- The 5th Edn should include the QAIHC recommendations for meeting this criterion (see below).

Meeting this criterion:

In this submission we provide the following suggestions to guide health care services. We recommend the 5th edition include these suggestions:

- ▶ C. "*Our patients are included in decisions and choices made about their care*".

Practices can enhance patient participation in decisions about their care (shared decision-making) by:

- Using decision aids that may help patients to make decisions¹⁰ and clinical care pathways (such as those developed by Primary Health Networks) to streamline the patient journey
- Using feedback from patients themselves to ascertain if the practice supports patients to be included in their care (*See Criterion 1.2B from Module 2*)
- Engaging with patients, their families, consumers in service design and redesign, and/or health service governance and oversight roles¹¹

¹⁰ <http://www.racgp.org.au/download/Documents/Tools/The-RACGP-General-practice-patient-charter-implementation-guidelines.pdf>.

¹¹ Consumers Health Forum of Australia. Capturing, analyzing and using consumer health experience narratives to drive better health outcomes. Real people, real data project. January 2013. Page 33.

- Incorporating the Charter or an equivalent statement in all job descriptions¹²
- Engaging with the community to gain insight into community needs through needs assessment
- Using quality improvement tools to measure the quality of shared decision-making¹³
- Supporting staff to gain skills in how to obtain patient input into the treatment options, to consider the pros and cons, the expected outcomes, success rates and incidence of side effects as they may affect the patient,¹⁴ and encourage question-asking and checking that the questions have been satisfactorily answered.¹⁵

► D: *“Our patients are supported to self-manage their disease or illness”.*

Practices can support and enhance self-management of disease or illness by:

- Undertaking the above
- Using ‘health systems assessment’ tools that include self-management as a domain, as a continuing quality improvement activity
- Using standardized ways to routinely assess and document the self-management needs of clients (eg in care plans, using online tools)
- Auditing the quality of care plans as a CQI activity (eg ensuring that care plans are condition-specific, include patient goals, tailored to the unique needs of the patient, include the family, etc)
- Ensuring access to good quality educational resources for self-management for patients and their families, and/or referring patients to services that can provide peer support
- Utilising home medicines reviews.

Justification for the recommendation:

- The 5th edn states that: “...employees ...give the patient time to provide input and participate actively in decisions regarding their healthcare.”¹⁶ However, none of the current indicators in this standard reflect this intention.
- The 5th Edn (June 2016 draft) has revised the statement that ‘consultation should be patient-centred’ to ‘consultation must be patient-centred’. In order for consultation to be patient-centred, it must (by definition) actively involve patients in decision-making. Practices need guidance on how they may better involve patients in decision-making. Patients/consumers need to be aware that their right

¹² ACSQHC. About the Australian Charter of Healthcare Rights: A guide for healthcare providers. <http://www.safetyandquality.gov.au/national-priorities/charter-of-healthcare-rights/>

¹³ Janamian T, Upham SJ, Crossland L, Jackson CL. Quality tools and resources to support organisational improvement integral to high-quality primary care: a systematic review of published and grey literature. *Med J Aust.* 2016 Apr 18;204(7):S22-S.

¹⁴ National Institute for Health and Clinical Excellence. Clinical Guidance- Patient experiences in adult NHS services: improving the experience of care for people using adult NHS services. National Clinical Guideline Centre, the Royal College of Physicians, London, February 2012. Page 31.

¹⁵ <http://www.racgp.org.au/download/Documents/Tools/The-RACGP-General-practice-patient-charter-implementation-guidelines.pdf>

¹⁶ Page 30; Draft 5th Edn (Feb 2016); and page 15 (June 2016)..

to be included in decisions and choices about their care is considered best practice by the general practice sector.

- The RACGP Patient Charter states that: *“shared decision-making is an important aspect of patient-centred care. It is a process that enables clinicians and patients to participate jointly in making a health decision.”* None of the current indicators in the 5th Edn reflect this intention.
- Health professionals are experts about disease, but patients are experts about their lives. Patients live with their illness and disease 24 hours a day and have unique goals, wishes, capacities and supports to live life with the least disability and optimize their health outcomes. To do this, they need to be partners in the management of their condition. This requires them to know how they can best self-manage their condition and be empowered to cope with the demands of their illness. Self-management is now a core part of illness care, and needs to be included in best practice standards of care.^{17 18}
- The *National Safety and Quality Health Service Standards* (Version 2), place greater emphasis on partnerships with consumers as fundamental for ensuring safety and quality:¹⁹

“The need to provide care that is based on partnerships and aligns with the expressed preferences and healthcare needs of consumers underpins all of the NSQHS Standards.”

- The ability to involve patients in decision-making and planning their treatment, and to enable patients to make a fully informed choice amongst many options is a core standard for Australian medical graduates (standards 2.8, 2.9).²⁰
- The above QAIHC recommendations are consistent with this intent.

Standard 2: Rights and responsibilities of patients

Criterion 2.1- Respectful and culturally appropriate care

The 4th Edn standards (indicator 2.1.1 G) recommended the following practice commitment: *“Our practice team can identify important/significant cultural groups within our practice and outline the strategies we have in place to meet their needs.”* However, this indicator is no longer in the 5th edition.

The draft 5th edition (February 2016) indicator (3.1 B) was redrafted thus: *“Our practice is aware of identified cultural groups of our patient population.”* Moreover, it was not a mandatory indicator.

The draft 5th edition (June 2016) has now eliminated the above indicator and does not include any indicator on this issue.

There is no indicator that pertains to managing health inequalities, yet this issue is mentioned in the 4th edn and 5th edn of the Standards.

¹⁷ Flinders Human Behaviour and Health Research Unit, Department of General Practice, School of Medicine, Spencer Gulf Rural Health School, Centre for Allied Health Evidence, & School of Nursing and Midwifery (UniSA). *Educating future health care professionals to support people with chronic conditions to live better and live longer. A chronic condition self-management support tertiary education curriculum framework.* Flinders University, 2007.

¹⁸ Primary Health Care Advisory Group. Primary Health Care Advisory Group Final Report Better Outcomes for People with Chronic and Complex Health Conditions. Commonwealth of Australia, 2016.

¹⁹ ACSQHC. *National Safety and Quality Health Service Standards. Version 2: Consultation Draft,* Commonwealth of Australia, 2015. Page 4.

²⁰ Medical Board of Australia. Accreditation Standards for Primary Medical Education Providers. 2012.

Although no explanation for the removal of the above indicators has been provided by the RACGP in the release of the June 2016 draft of the Standards, QAIHC has assumed that the RACGP intend for Criterion 2.1A to absorb the above indicators when it reads: *“Our practice, in providing patient healthcare considers patient rights and cultural beliefs.”*

QAIHC Recommendation:

- Standard 2 to retain the indicator (2.1A):
 - ► A. *“Our practice, in providing patient healthcare considers patient rights and cultural beliefs.”*
- Standard 2 to include an additional indicator (2.1B) as phrased in the February 2016 draft:
 - ► B. *“Our practice is aware of identified cultural groups of our patient population.”*
- Standard 2 to include an additional indicator (2.1C) and be worded as follows:
 - ► C. *“Our practice can outline the strategies we have in place to respond to specific cultural needs.”*
- Indicators 2.1A, 2.1B and 2.1C should be mandatory.
- The 5th Edn to include the QAIHC recommendations for meeting this criterion (see below).

Meeting this criterion:

In this submission we provide the following suggestions to guide health care services. We recommend the 5th edition include these suggestions:

- Practices can engage with the community and representative groups/organisations to enhance the responsiveness of their service to specific cultural groups
- Practices can collaborate formally or informally with Aboriginal Community Controlled Health Services, Aboriginal Community Controlled Health regional and state governing bodies
- Practices can configure disease registers to identify cultural groups to target specific initiatives for reminders, recall, and health promotion
- Practices can use feedback from patients themselves to assess if the practice is responsive to Aboriginal and Torres Strait Islander patients or other cultural groups (see *Criterion 1.2, Module 2*).

Justification for the recommendation:

The 5th Edn Standards (June 2016) states that: *“It is important for practices to understand their patient population, as this will ensure that the most appropriate care is provided.”* In order for practices to *“understand their patient population”*, they must be able to identify cultural groups in their practice population.

The 5th Edn Standards (June 2016) states that: *“When clinical staff ask patients about their cultural beliefs (e.g. Aboriginal or Torres Strait Islander status) for the purposes of updating the patient’s details, it is a good idea to explain that you need*

to ask these questions in order to provide culturally sensitive care.” The application of culturally sensitive care depends on whether there are systems to identify cultural groups.

The RACGP recommend that practices: “use a clinical audit tool to identify cultural groups in your population” as an example of an optional strategy to meet Indicator 2.1A. However, this strategy better reflects the QAIHC proposed Indicator 2.1B. If a practice undertakes a clinical audit to identify cultural groups, it does not demonstrate that the practice considers cultural beliefs.

Indicator 2.1A is better demonstrated through a strategy such as: “Provide cultural safety training for staff members and keep records of the training in the staff training register.”²¹

All practices should be responsive to patients with specific cultural needs. This is consistent with Australia’s Charter and requires more than merely being aware of identified cultural groups in the patient population. Patients who have specific cultural needs include Aboriginal peoples and Torres Strait Islanders.

Increasing the health systems responsiveness to Aboriginal peoples is a priority for Primary Health Networks.²² The *National Safety and Quality Health Standards* now include measures to assure the responsiveness of hospitals to Aboriginal peoples.²³

“Where Aboriginal and Torres Strait Islander people receive care in the organisation, the highest level of governance ensures that the safety and quality goals address the specific health needs of these people. (GS1.2) Where there are specific safety and quality goals for Aboriginal and Torres Strait Islander people, the health service organisation has targeted strategies to meet these goals. (GS2.2)”

The RACGP 5th Edn Standards need to be consistent with advances in the hospital sector, and the imperative to identify Aboriginal peoples in all Primary Health Network boundaries (as indicated above). The Standards must include appropriate indicators that can support practices to:

- Identify cultural groups like Aboriginal peoples and Torres Strait Islanders, and
- Respond to specific cultural needs.

There is evidence that private general practices continue to have problems identifying Aboriginal peoples and Torres Strait Islanders in their patient population. As a result, they are unable to respond adequately to the needs of this population. For example, poor uptake of health checks (item 715) persists despite the PIP Indigenous Health Incentive. Continuing barriers include Indigenous status under-identification and lack of awareness of health checks as good practice.²⁴

Standard 6: Continuity of care

Criterion 6.2- Clinical handover

Indicator 6.2A is mandatory and states:

²¹ Page 46, 5th Edn Standards (Feb 2016), and page 35 (June 2016).

²² Ley S. New Primary Health Networks to deliver better local care. Department of Health, Australian Government. 2015; 11 April. <http://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2015-ley036.htm>

²³ ACSQHC. *National Safety and Quality Health Service Standards. Version 2: Consultation Draft*, Commonwealth of Australia, 2015. Page 11.

²⁴ Schutze H, Pulver LJ, Harris. The uptake of Aboriginal and Torres Strait Islander health assessments fails to improve in some areas. *AFP* 2016 45:6: 415-420.

- *“Our practice manages the handover of patient care”.*

However, this section does not adequately describe the practice obligation to transfer clinical information to shared electronic medical records when this is requested by the patient, in order to support the *informational and management continuity* of that patient.

QAIHC Recommendation:

- Criterion 6.2 (‘Clinical handover’) to include a new indicator (6.2B) reflecting the commitment to patient-centred care and continuity of care:
- Indicator 6.2B could state:
 - ► *“Our practice is capable of transferring clinical information to shared electronic medical records such as the My Health Record, when this is requested by the patient.”*

Meeting this criterion:

In this submission we provide the following suggestions to guide health care services. We recommend the 5th edition include these suggestions:

- Clinical handover may also be necessary when the patient requests this. For example:
 - uploading shared health summaries to the patients *My Health Record*.
- Examples of how a practice might choose to meet this Criterion should include:
 - Use of practice software such as patient information and management systems that permit NEHTA-enabled uploads of shared health summaries/records or event summaries to their *My Health Record*, at the request of the patient;
 - Participation of the practice in the e-health Practice Incentive Payment.

Justification for this recommendation:

The *My Health Record (MyHR)* is a national health initiative that has been welcomed by the Consumers Health Forum (CHF) of Australia.²⁵ This is because Australians believe it has the potential to improve continuity of care, decrease duplication of tests, and reduce adverse medical events. The CHF state:

“We need all GPs and other health professionals to get behind My Health Record, for the benefit of patients and their own work efficiency and effectiveness... My Health Record is a key building block for a more effective, connected health system and a powerful vehicle for ensuring better linkage and coordination of care in the consumer’s interest”.

Despite the core obligation that general practices have in facilitating the uploading of clinical information onto the MyHR when patients request it, the Standards do not include any mention of this obligation.

There is an exponential uptake of the MyHR by hospitals across Australia. In Qld, 90% of hospitals have connected to MyHR, and are uploading discharge summaries.

²⁵ Consumers Health Forum of Australia. My Health Record roll-out a step forward for Australia, says the Consumers Health Forum. March 2016. <https://www.chf.org.au/pdfs/chf/20160304-eHealth-takes-important-step-forward.pdf>

As at 22 May 2016, around 390,000 discharge summaries had been uploaded to the system. Pathology results will also soon be uploaded. Around 5000 shared health summaries are being created per week in MyHR by general practices.²⁶

Aboriginal peoples and Torres Strait Islanders are at a higher risk of medical misadventure. Due to the disproportionate impact that social determinants of health have on their lives, Aboriginal peoples have lower rates of medication adherence. Their higher degree of geographic mobility warrant use of systems by general practices to support management and informational continuity, such as through the MyHR.

Module 2: Quality Improvement Module

Standard 1: Quality Improvement

Criterion 1.2 – Patient Feedback

Both the 4th Edn and 5th Edn (February 2016) of the Standards contained a Criterion for patient feedback requiring patient feedback to be assessed at least once every three years, and to “*seek and respond to feedback collected from patients, carers and other relevant parties on an ongoing basis*”. (Indicator 1.2A and 1.2B respectively in the February 2016, 5th Edn of the Standards).

The June 2016 version of the 5th Edn Standards has softened this obligation. Indicator 1.2A now states: “*Our practice seeks feedback from patients, carers and other relevant parties in accordance with the RACGP’s Patient Feedback Guide.*” However, the RACGP Patient Feedback Guide is due to be revised in 2016 and is not currently available for comment.

The key change is with the frequency of patient feedback assessment. Formal patient feedback to be collected at least once every 3 years is still a recommendation, but this is now optional.²⁷ There is also the option of collecting feedback on an ongoing basis. In other words, patient feedback can now be sought on an ongoing basis **or** at least once every three years. **This means that practices have no obligation to seek regular ongoing patient feedback.**

This is contrary to Australian and international contemporary practice fostering **patient reported experiences** as one of three pillars of quality care in addition to clinical effectiveness and safety quality care measures. Patient reported experiences are a measure of patient-centred care.²⁸ Moreover, **the involvement of patients and community members in governance and the design/redesign of services should be recognized as a form of patient feedback.**

QAIHC Recommendations:

- Standard 1 should clearly articulate the expected standard for contemporary practice with regard to eliciting patient feedback. Merely stating ‘*in accordance with the RACGP Patient Feedback Guide*’ is unclear and misleading.

²⁶ Personal communication, Department of Health, May 2016.

²⁷ RACGP 5th Edition, page 118 (June 2016 draft)

²⁸ NSW Agency for Clinical Innovation. Integrated Care- Patient reported outcome measures and patient-reported experience measures- a rapid scoping review. ACI, NSW, 2014
<http://www.aci.health.nsw.gov.au/resources/integrated-care/aci/patient-reported-measures>

- Indicator 1.2A should be changed, be mandatory, and should state:
 - ► “Our practice seeks and responds to feedback collected from patients, carers and other relevant parties on an ongoing basis”.
- The 5th edn standards should define the word: ‘ongoing’. This definition should be included in the glossary and reflect best practice.
- QAIHC agrees that 3- yearly commercial patient feedback surveys **should be optional**. If they are undertaken, they should be conducted *in addition to* ongoing feedback.
- Practices should also ensure that ongoing feedback includes a representative proportion of Aboriginal and Torres Strait Islander patients and other cultural groups in this ongoing feedback.
- The *Resource for the Standards* and the *RACGP’s Patient Feedback Guide* should mention that commercial patient feedback surveys contain questions that assess patient experiences on matters that are considered patient rights. This is relevant to other indicators in the Standards that pertain to ‘patient participation’ (see Criterion 1.3). An example of such a question is:
 - ‘I am better able to make decisions about my health’. [*Likert scale responses*].
- The *RACGP Patient Feedback Guide* should include updated information to assist services to improve the quality of the ‘ongoing’ feedback they elicit and receive from patients. The description in the Standards is insufficient to guide quality improvement. The new resource should provide examples of short questionnaires that can focus on key domains of quality, including the clients perception of the quality of care. Note that the existing draft “*Resource Guide for the RACGP Standards for general practices, 5th Edition*” does not provide any guidance on this issue.²⁹
 - This resource should also include examples of ways to seek ongoing feedback from patients who Aboriginal and/or Torres Strait Islander to enhance the responsiveness of the service to this population.
 - Eg. A short questionnaire has been developed by the Lowitja Institute that can be used every 12 months or more frequently for patients with a chronic condition. A single page contains 18 questions including several exploring the patients perception of how included they felt in decisions about their care.³⁰
 - This resource should elaborate on the *key domains of quality* that include the client’s perception of the quality of care, patient experiences, and how practices may determine if patients rights have been respected (as articulated in the Charter).
 - This resource needs to guide practices to offer patients real-time and online mechanisms for ongoing patient feedback.
 - This resource should include guidance on how practices can act on patient feedback.
 - Stakeholders for the development of this resource should include NACCHO, Aboriginal and Torres Strait Islander Community Controlled Health Services and consumer representatives.

²⁹ <http://www.racgp.org.au/your-practice/standards/standardsdevelopment/>

³⁰ Lowitja Institute. The consumers perspective of the quality of care. <http://www.lowitja.org.au/cpqoc#sthash.NE0wD1bv.dpuf>

- The 5th Edn Standards should include the QAIHC recommendations for meeting this criterion (see below).

Meeting this criterion:

We recommend the 5th edition include these suggestions. The practice could demonstrate support for patient feedback by:

- Using the results of *either* the 3-yearly and ‘ongoing’ patient feedback mechanisms to incorporate in a PDSA cycle.³¹ (*There is no clarity about using both sources of feedback for PDSA cycles in the draft standards*).
- Using existing short patient experience surveys that have been tailored for use with Aboriginal and/or Torres Strait Islander patients.
- Using short patient experience surveys that include questions about whether patients have received the Charter, and whether the rights in the Charter have been respected.³²
- Ensuring the Charter is used as a reference point in the management of complaints.³³
- Complementing survey methods with other qualitative strategies that explore key domains of quality. These strategies might be:
 - verbal comments and concerns provided to the management or staff by patients or their family members,
 - patient stories known as ‘narratives’ (written, videoed, Photovoice),
 - focus groups,
 - patient ‘shadowing’ (following a patient as they progress through the health service),
 - other ways preferred by patients.
- Utilising patient co-design strategies (patients/consumers partner with the service to observe daily processes to identify factors that affect the patient experience).³⁴
- Utilising community governance mechanisms (such as community Boards) as a mechanism to convey and act upon patient experiences.
- All methods of patient feedback should be documented and acted upon in quality improvement cycles as a routine. For example, this could be demonstrated by:
 - PDSA cycles that are informed by patient feedback. [*This advice should be included with respect to indicator 1.2B, Module 2*]. It is important to track changes in patient feedback over time.

Justification for this recommendation:

A 3-yearly interval for patient feedback is a long interval and is inconsistent with the

³¹ RACGP patient feedback guide.

³² Australian Charter of Health Care Rights.

³³ Ibid

³⁴ Consumers Health Forum of Australia. Capturing, analyzing and using consumer health experience narratives to drive better health outcomes. Real people, real data project. January 2013. Page 15.

need for regular and frequent Continuing Quality Improvement (CQI) systems. As it is a costly process to commission commercial feedback surveys, a balance needs to be found so that surveying does not overburden patients and practices.

The recommendation for ongoing feedback is therefore important and reflective of contemporary practice. NSW Health developed a four-year strategic plan (2014-17) committing \$120 million to implement locally led models of integrated care across the State. A priority area was investment in better measurement, tracking and feedback of patient experiences and outcomes across the system to achieve better patient-centred care. The investment also included use of tools enabling 'real-time' patient feedback to measure the experience of the patient immediately after or during treatment, and prompt feedback loops to address any issues.³⁵

Longstanding initiatives in the UK include the *NHS Outcomes Framework* where feedback from patients on their experiences and their participation in health care decisions is collected from them and form key domains of quality care. Data from all the domains helps to measure levels of improvement across primary health care services and progress *in reducing health inequalities* and unjustified variations in care.³⁶ The inclusion of patient experience as a core outcome measure arose from the Francis inquiry in the UK (2013). This inquiry investigated significant failures in the duty of care to patients attending a hospital. The inquiry revealed that the failure to 'put the patient first in everything that is done' was a key determinant of poor standards. The lack of patient involvement was 'a conspicuous failure'. This led to a recognition that 'there must be real involvement of patients and the public in all that is done'.³⁷

In the USA, patient reported outcomes are being integrated into electronic health records as a core measure of quality.³⁸

The UK Health Foundation, a not for profit agency committed to improved healthcare quality has reported:

- *"The measurement of patient experience may work best if it is viewed as a routine part of clinical practice."*³⁹

Collecting ongoing feedback from patients is important, but without additional support, the quality of this feedback is likely to be poor. If quality is to improve, health services will need extra support to improve their ongoing patient feedback systems.

The RACGP could assist practices to consider collecting ongoing feedback on a variety of domains of quality. Key domains include patient experiences such as their participation in health care decisions, and the support they receive for self-

³⁵ NSW Agency for Clinical Innovation. Integrated Care- Patient reported outcome measures and patient-reported experience measures- a rapid scoping review. ACI, NSW, 2014
<http://www.aci.health.nsw.gov.au/resources/integrated-care/aci/patient-reported-measures>

³⁶ NHS Group, Department of Health. The NHS Outcomes Framework 2015/16. Department of Health, London, 2014.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/385749/NHS_Outcomes_Framework.pdf

³⁷ Francis R. Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. London, 2013.
<http://webarchive.nationalarchives.gov.uk/20150407084003/http://www.midstaffpublicinquiry.com/sites/default/files/report/Executive%20summary.pdf>

³⁸ NSW Agency for Clinical Innovation. Op.cit.

³⁹ The Health Foundation. No.18 Measuring Patient experience. Evidence Scan. UK, June 2013. Page 31.

management.⁴⁰

The RACGP recognize that quality patient feedback is vital to the quality improvement of health services. The current *RACGP Patient Feedback* guide states:

- “Leaving blank questionnaires at reception will not allow you to get a representative sample of patients because only those who are genuinely interested and have something specific to say about your practice will bother to complete it.”

If patients are only offered unstructured feedback opportunities such as complaints boxes, the utility of their feedback is reduced.

- “The poorest care is often received by those least likely to make complaints, exercise choice or have family to speak up for them.”⁴¹

Patients will need guidance regarding their health care rights and measures of quality when providing ongoing feedback. For example, patients should be informed about the several domains of quality they might wish to consider. Patients should have access to proformas to help them structure their feedback. These can be prepared in partnership with ACCHSs, regional ACCHOs, NACCHO Affiliates and NACCHO together with the Consumers Health Forum.

It should not be necessary for practices to use validated commercial patient feedback tools unless they choose to use them.⁴² There is an argument that it is more important to tailor the feedback method **to the patient and practice context** and to use the findings to drive quality improvement. This has led to the acceptance of a range of patient experience measures such as patient narratives, co-design and other methods that enable patients/consumers to participate in optimizing the quality of their care.⁴³

Commercial feedback instruments focussing excessively on *functional aspects of care* such as waiting times, choice of doctor, and some *relational aspects* like patient satisfaction,⁴⁴ may not be a priority nor have much utility for CQI.⁴⁵ Patient feedback surveys should assess more than just ‘patient satisfaction’.⁴⁶ ‘Satisfaction’ is a weak measure of quality. Patients tend to overrate ‘satisfaction’ due to gratitude bias and other factors. Evidence suggests that most people are satisfied with their health care regardless of the quality of the care they receive – even those who have negative experiences are satisfied with the care they received.⁴⁷ Hence, it may be difficult to use ‘patient satisfaction’ surveys to drive quality improvement. In comparison, feedback on patient experience seeks out information on what happened to patients

⁴⁰ National Institute for Health and Clinical Excellence. Clinical Guidance- Patient experiences in adult NHS services: improving the experience of care for people using adult NHS services. National Clinical Guideline Centre, the Royal College of Physicians, London, February 2012.

⁴¹ NHS England. Domain 4: Ensuring that people have a positive experience of care. NHS Outcomes Framework. <https://www.england.nhs.uk/resources/resources-for-ccgs/out-frwrk/dom-4/>

⁴² The Health Foundation. No.18 Measuring Patient experience. Evidence Scan. UK, June 2013. Page 29.

⁴³ Consumers Health Forum of Australia. Capturing, analyzing and using consumer health experience narratives to drive better health outcomes. Real people, real data project. January 2013

⁴⁴ The terms ‘patient satisfaction’ and ‘patient experiences’ mean different things. ‘Satisfaction’ is a weak measure of quality. Patients tend to overrate satisfaction due to gratitude bias and other factors. Feedback on patient experiences seeks out information on what patients happened to patients and the extent to which their needs were met.

⁴⁵ Allan J, Schattner P, Stocks N, Ramsay E. Does patient satisfaction of general practice change over a decade? *BMC Fam Pract*. 2009 Feb 8;10:13. doi: 10.1186/1471-2296-10-13

⁴⁶ Australian Institute of Health and Welfare 2014 The measurement of patient experience in non-GP primary health care settings. Cat. no. WP 66.Canberra: AIHW

⁴⁷ Russell S. Patients’ Experiences: Top heavy with research. Research Matters: Melbourne, 2013.

from the patient's perspective. This helps services to determine if what actually happened reflects what ought to have happened. These measures can improve chronic disease outcomes.

Practices will also need guidance so that they can offer patients real time and online mechanisms for ongoing patient feedback.

In addition, there is a need for guidance on how practices can act on patient feedback. Patient feedback needs to be used as a driver for change at the practice level. This means that strategies for quality improvement such as use of PDSA cycles, staff training etc, need to also include patient reported experiences as a source of information.

'Patient feedback' describes the *individual* experience of care, but patient or consumer participation in primary health care can also involve patient groups and families influencing service design, through governance and oversight roles as takes place within ACCHSs. ACCHSs offer patients and community members an opportunity to participate in decisions about their health care across a whole continuum from complaints boxes to co-design and governance. The fact that patient feedback mechanisms can operate across these levels within health services is not recognised in the RACGP Standards, but needs to be, given changing models of care within general practice and the primary health care system towards patient-centeredness [See also QAIHC recommendations for Standard 1, Module 1 on this matter].

At the recent QAIHC CQI Conference (July 2016), 75% of participants (25/33) reporting using survey methods as well as other methods to elicit patient feedback, with almost universal views that services should obtain feedback from patients. Two thirds of participants reported using patient feedback data for CQI just like the use of clinical measures for CQI. 100% of participants (41/41) said that they would welcome support on ways to get and use patient feedback for CQI. Many services reported using focus groups and discussions with patients as ways to seek patient feedback. Most services agreed (92%, 39/42) that if other methods to obtain patient feedback were used for CQI, then the use of commercial patient feedback surveys recommended for accreditation should be optional.⁴⁸

In summary, there is a need for a resource to assist practices to elicit quality patient feedback on an ongoing basis and to respond to it. The development of that resource should include NACCHO/Affiliates/ACCHS and sufficient numbers of Aboriginal and other consumer representatives.

Criterion 1.3- Improving Clinical Care

Indicator 1.3B stipulates that: "*Our practice team undertakes activities aimed at improving clinical practice*". However:

- this indicator is not specific about the period of time to undertake this type of activity which is explained in the Standards to be clinical audit or a PDSA cycle. Moreover, the Standards refer to this type of activity being conducted at least once every three (3) years;
- this indicator is not mandatory.

⁴⁸ Couzos S. The patient's perspective of the quality of care. Can patient feedback surveys add value to the quality improvement activity of Aboriginal and Islander Community Controlled Health Services? QAIHC Continuing Quality Improvement Workshop, Hotel Grand Chancellor, 27-28 June 2016, Brisbane.

QAIHC Recommendation:

- Indicator 1.3B should be mandatory
- Indicator 1.3B should specify that at least *annual* activity aimed at improving clinical practice should be undertaken.

Meeting this criterion:

We recommend the 5th edition include these additional suggestions. The practice could demonstrate support for activities aimed at improving clinical practice by:

- Undertaking reviews and analyses of certain MBS claims data to identify gaps in the delivery of comprehensive primary healthcare to priority populations (eg Items 715 and/or 723);
- Utilising data reports that benchmark the practice to identify gaps, areas and opportunities for improvement so as to assist in health service planning.⁴⁹ This can be done by participating in quality improvement programs such as Australian primary Care Collaboratives; programs supported by PHNs; and NACCHO Affiliates or regional ACCHOs.

Justification for this recommendation:

The Standards need to be consistent with current standards of quality assurance and continuing quality improvement in other health sectors. Many general practices and all ACCHSs participate in regularly scheduled monthly clinical audit and PDSA cycles as part of routine care.⁵⁰ The current e-health environment simplifies the process of clinical audit enabling regular CQI activities. The 5th edition standards contain no other indicator that requires practices to demonstrate engagement in CQI activities to benchmark service activity.

In order to embed the three pillars of quality care as best practice (patient experiences, clinical effectiveness, and safety), CQI activities must be core business.

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49 QAIHC. Benchmarking Report. Health Information Unit, Brisbane, 2016.

50 Lowitja Institute. Recommendations for a National CQI Framework for Aboriginal and Torres Strait Islander Primary Health Care. Australian Government, Department of Health. Canberra, 2014.
<http://www.health.gov.au/internet/main/publishing.nsf/content/cqi-framework-atsih>



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