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AMA Submission to Review of General Practice Accreditation Arrangements

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Introductory questions

1. What is your name?

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2. What is your email address?

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3. Do you consent for your submission to be published in whole or in part? *Required.*

Yes

4. Do you consent for your name or your organisation's name to be published in recognition of your participation in this Review? *Required.*

Yes – organisation's name only

5. Are you providing comments on behalf of an organisation? *Required.*

Yes

6. Do you agree to mpconsulting contacting you with any questions regarding your submission? *Required.*

Yes

Questions for organisations

7. Please provide the organisation's name. *Required.*

Australian Medical Association

8. **Which of the below best describes your organisation?** *Required.*

- Peak body

Questions for individuals

7. **Which of the following best describes your role?** *Required.*

- Other – Senior Policy Adviser

Consultation Paper questions – General practice accreditation

Impact of general practice accreditation

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

Accreditation:

- provides independent recognition and assurance that a general practice meets the safety and quality standards set by the profession;
- demonstrates a practice's commitment to safety and quality and continuous improvement;
- supports risk management;
- contributes to the continuing professional development of GPs and other staff; and
- provides a marker of quality assurance that can be linked to Government funded programs.

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)?

The barriers are:

- the administrative burden – the standards require practices, which are primarily small business, to develop and maintain a comprehensive range of policies and processes to demonstrate the requirements of various criterion indicators are being met. These are perceived to be overly burdensome at times and sometimes stray into areas well outside the standards of clinical care provided to patients);
- the time commitment – the time that practices commit to accreditation goes beyond the site visit and includes, policy preparation, auditing and updating, creation and maintenance of registers, creation and maintenance of practice procedures, and participation in quality improvement initiatives and research;
- the cost – includes not only the direct costs of assessment but, as noted in the consultation paper, the ongoing costs associated with maintaining accreditation; and
- concerns that Government will revise incentives linked to accreditation, which has the potential to significantly impact on practices finances and the cost benefit ratio of accreditation. Examples of this include:
    - increasing the required benchmarks for eligibility such as under the old Diabetes, Cervical Screening and Asthma Incentives; and
    - adding new eligibility requirements such as requiring Shared Health Summary uploads under the e-Health Incentive – when initially proposed around 40% of practices indicated they wouldn't be able to comply and one third facing over a $20,000 reduction in incentive payments.

- capital expenses when revisions of the Standards introduce new infrastructure requirements – such as dedicated vaccine fridges, height adjustable beds, timely access to a spirometer and electrocardiograph, and a defibrillator (advised but not mandatory currently).

Despite these barriers, the participation of practices in accreditation is high because they see an overall benefit from it. That said, it is critical that accreditation requirements remain reasonable as any further red tape impost may well see some practices reconsider their involvement. In addition, it is important that practices have certainty of funding when it is linked to accreditation to ensure that sudden changes do not result in their departure.

Governance

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

They key strength of general practice accreditation is that it is profession led, although the involvement and actions of the Commission for Safety and Quality in Health Care (the Commission) continues to be of concern to stakeholders. There is a sense that the Commission has a broader agenda to take over accreditation arrangements for general practice, which would undermine the status of general practice accreditation in the eyes of the profession.

The AMA position statement on General Practice Accreditation strongly supports accreditation being independent of Government and in relation to the NGPA Scheme, its key strength is that no one is party controls all aspects of the scheme and the roles of each party are delineated, for example: funder; regulator of accrediting agencies; standards setter; and voluntary participant.

It is important that this delicate balance be maintained that AMA would not support changes that substantially changed this. In particular, the role of the Commission should not be expanded beyond its current remit, which is to:

- approve accrediting agencies;
- monitor and report on the performance of the accrediting agencies with regard to:
    - equity of access to the accreditation process;
    - consistency and fairness of accreditation assessments; and
- identify and work with the accrediting agencies on areas for improvement.

In this regard, it is noted that the development of the NGPAS was in response to the recommendation by the Australian National Audit Office that the Department of Health needed to develop the means to inform itself of the quality of general practice accreditation[1]. The Commission's remit should not go beyond this objective.

To date the greatest limitation of the NGPAS is the lack of transparency with no published data on the performance of (deidentified) accrediting agencies. The Scheme has been in place since 1 January 2017.

The AMA rejects concerns expressed about the operation of qualified privilege. That being that the accuracy and completeness of data provided to the Commission is undermined The AMA believes

[1] Recommendation 3. ANAO Audit Report No.5 2010–11. Practice Incentives Program0

this concern is without merit and reflects a desire by the Commission to interfere with a professional led process.

The AMA position on Qualified Privilege is that accrediting bodies must hold a Declaration of a Quality Assurance Activity (Qualified Privilege) and ensure that surveyors comply with these arrangements. Qualified Privilege provides reassurance to GPs and general practices that the information they provide will not be used against them and encourages participation in the accreditation process and supports quality improvement.

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?

To ensure that contextual environment of general practice is taken account of it is vital that those with clinical and administrative experience in general practice are predominantly involved in the development of standards and the assessment of practices against the Standards.

The Standards

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

Strengths:

- the Standards are profession-led and evidenced-based, and are developed after extensive consultation with the profession;
- the Standards development process helps ensure that the Standards are generally relevant and fit for purpose;
- the Standards evolve overtime to reflect current evidence;
- patient feedback informs practices on their performance;
- the Standards support general practices to identify and address any gaps within their systems or processes in the continuous pursuit of providing quality care delivered safely; and
- the Standards are widely accepted by general practice.

Limitations:

The outcomes focus of the 5th edition Standards seems to have created a conflict of purpose and confusion for practices when it comes to accreditation. The focus on outcomes provides some flexibility for practices to demonstrate how they meet indicators (reflecting their diversity). Yet, the related guidelines are interpreted by some practices as being prescriptive and members have complained to the AMA of indicators being assessed as not met because the practices does this in a way different to that suggested in the guidelines.

It is important that the Standards seek to support the profession on a journey of continuous improvement, often in a very resource constrained environment. Practices should be encouraged to innovate and a one size fits all approach to the Standards and assessment against these must be avoided.

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 AMA acknowledges that the Standards are tested and piloted before introduction. Reporting the outcomes of these pilots would help practices better understand how they are developed and give greater confidence that they are relevant and fit for purpose. In addition, the College should look to encourage and support the involvement of a diversity of practices in their testing and piloting phase.

Assessment against the Standards

Requirements for accrediting agencies

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

The AMA appreciates that the Commission's oversight of accrediting agencies provides general practices and the Department of Health with some reassurance that accrediting agencies are all operating to a standard and a comparable fashion. However, the AMA is yet to appreciate the benefit of monthly reporting by the accrediting agencies to the Commission. The AMA would expect that the necessary information to assess the performance of accrediting agencies and the accreditation process itself could be done just as effectively with the provision of quarterly data.

The AMA strongly supports the current requirements for accrediting agencies to ensure at least one member of the accreditation assessment team is a GP. This is essential to the proper interpretation of the standards and their application. The involvement of peers assists with the acceptance of the accreditation process and supports practices in effective quality improvement.

The AMA is concerned that provisions in Appendix 2 of the Commission's *Policy -Approval under the National General Practice Accreditation (NGPA) Scheme to conduct accreditation of general practices using the Royal Australian College of General Practitioners (RACGP) Standards for general practices* with respect to actual and perceived conflicts and apprehension of bias are too restrictive and this potentially limits the pool of available assessors. Provided the potential conflict is recorded it should not prevent the surveyor's participation, provided the surveyor is acceptable to the practice. Utilising surveyors who are familiar with the practice may be more efficient and support the development of a trusted relationship that assists assessors when discussing opportunities for quality improvement.

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

Current arrangements could be improved by:

- granting and maintaining accrediting agencies qualified privilege; and
- reviewing, in consultation with the accrediting bodies, the RACGP and other key stakeholders, clauses 3.3.2 and 3.3.3 in the abovementioned Appendix 2.

Assessment approach

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

Strengths:

- practices have the opportunity to self-assess ahead of a site visit, providing an opportunity for reflection;
- having an assessment team comprised of at least two surveyors both who are appropriately trained and experienced in general practice, with one being a GP;
- peer review and assessment feedback to practices is a valuable process in building and supporting a culture of quality improvement; and
- the intention that a common-sense approach is utilised when undertaking accreditation assessments.

Limitations:

- assessments can be onerous and disruptive to practices as it takes staff away from their normal duties and patient care – when preparing for and during assessment;
- utilising the same approach for all practices regardless of maturity in the accreditation process – for example full re-assessment every 3 years;
- the current emphasis on review of supportive documentation does not allow sufficient time for discussion and feedback to further quality improvement and;
- the current 3 year assessment process provides no ongoing assurance that standards are maintained in the interim.

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

JSANZ is implementing a Self Evaluation Mechanism (SEM) for entities accredited with them. Introducing a SEM for practices mature in the accreditation process could be beneficial in supporting quality improvement as the intent of the SEM is to help an entity to understand, sustain and improve their performance[2].

Introducing a process of ongoing assessment for practices already accredited and reducing the emphasis on the end of cycle assessment would provide greater assurance that compliance with the Standards is being maintained. Such a process should not add to the administrative burden for practices but rather spread that burden across the cycle and support greater integration of Standards compliance into the practice's workflow. With an ongoing and integrated approach to accreditation consideration could be given to lengthening the accreditation cycle.

On a more technical note the AMA advises that the requirements for GP surveyors need to be modified to reflect the implementation of the Health Insurance Amendment (General Practitioners and Quality Assurance) Bill 2020 to ensure that those GPs registered with the Medical Board in the specialty of general practice, or a Fellow of RACGP or ACRRM are eligible.

Non-conformance and remediation

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

[2] A self- evaluation mechanism for CABs. JSANZ. Sourced: 26 August 2021

Strengths:

- practices are advised shortly (within 5 days) after the initial accreditation assessment of matters requiring remediation, which is followed up with a written report (within 20 days);
- practices have up to 90 days (65 business days) to address the issues for remediation; and
- practices have access to an appeals process.

Limitations:

- access to resources and assistance to address non-conformance – eg practices may be unaware of what resources are available, some of these may involve a cost, or financial constraints may restrict capacity to invest in or upgrade equipment or technology within the deadline to demonstrate conformance.

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?

Enhancing practices awareness of and access to existing resources to assist in demonstrating Standards conformance could assist practices when responding to areas of non-conformance. This could also include any financial assistance or related tax benefits available to practices.

Cost 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.)

The AMA is unable to quantify these, particularly given the diversity of our GP membership. This is something that requires advice from practices through surveys or specific case studies. costs of accreditation

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

The AMA believes that there should be equity of access to the accreditation process. There should be no financial or other impediment to the ability of small practices, rural practices, remote practices and/or indigenous practices to access the accreditation system. This may well mean that there is some cross subsidisation reflected in fee setting arrangements.

Anecdotally, there are concerns that the fee structures of some accreditation services deliberately target large providers that have multiple practices. This allows cherry picking and means that other accreditation providers that seek to encompass practices of any size are at a disadvantage because of higher cost structures. This inevitably means that the economics of accreditation for smaller practices are much less attractive.

The AMA does not support any pricing model that prices smaller and rural practices out of the market.

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?

As fees for accreditation are generally commercial in confidence this is a matter for accrediting agencies to respond to taking account of the concerns raised around equity in access to accreditation. Practices may feel more supported, however, if the proportional cost of accreditation to average practice incentives was better understood.

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?

Practices could provide copies of their policies to the accrediting agency to demonstrate their compliance with indicators at the start of the accreditation cycle to narrow down the aspects that the accreditors may wish to examine at a site visit or during any staff interviews.

The AMA would suggest that where general practices are mature in the accreditation process, except for where a new Standard indicator has been implemented by the profession, that maintaining accreditation could shift to a different model of assessment that is more longitudinal in nature and less burdensome.

Data, duplication and continuous improvement

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

Strengths:

- collecting and analysing data on accreditation and the accreditation process is that it provides opportunities for benchmarking and continuous improvement for the accrediting agencies;
- data on the rate of accreditation provides public reassurance as to the safety and quality of care provided by general practices; and
- practices are free to publicise their accreditation status

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?

Data should be gathered only where there is a clear purpose for how the data will be used. Reporting requirements for accreditors must be purposeful. For example, reports could be provided at a PHN level and aggregated to track the proportion of practices accredited within the PHN. These could be broken down by rurality and practice size. This would inform the profession, Government, researchers and the community about accreditation participation.

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

The AMA would support incorporating the assessment of practices for GP training purpose into the broader practice accreditation program. This would be an additional component of accreditation and

would need to be designed by the RACGP, working in collaboration with stakeholders. This could streamline accreditation for training and could even extend to the supervision of students, prevocational trainees and international medical graduates.

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

With accreditation and the PIP closely linked, the AMA suggests that enhancing the PIP program with the introduction of more Service Incentive Payments (SIPs) for activities that support quality care and improvement would be of benefit. Possible options for SIPs could include coding key clinical information or uploading shared health summaries or reviewing a patient's My Health Record would enhance GP involvement in accreditation and quality improvement activities.

Consultation Paper questions – Training accreditation

Benefits of, and barriers to, training accreditation

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

Benefits:

- having the opportunity to be involved in:
    - enhancing the understanding of the role of general practice in the health system amongst future medical practitioners or health professionals
    - showcasing what general practice offers as vocation
    - contributing to the development and training of GP trainees
- provides opportunity train GP Registrars – benefits of which include opportunity for future recruitment to practice
- access to funding to support practices and trainers/supervisors involvement

Barriers:

- administrative burden of applying for accreditation for each purpose
- direct and opportunity costs in staff time associated with the completion of accreditation applications

Key issues

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

Strengths:

- standards are focussed on ensuring trainees training is provided in a supportive and safe manner;
- correlation between some of the requirements for complying with the standards for general practice as for training; and
- the focus for training accreditation is on ensuring a quality and safe training experience for GP trainees.

Limitations:

- aspects of accreditation process seem repetitive to practices

- remuneration for training or supervising viewed by some as not attractive enough to justify the costs and effort of seeking accreditation for training.

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?

- enhance awareness of the purpose for GP Training Accreditation and what opportunities it offers a practice and GP Supervisors; and
- develop a mechanism to minimise the duplicity in evidentiary documentation required; and

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.

Examples of opportunities for streamlining could include:
- combining aspects of the RACGP's Standards for general practice training Standard 1.1 with the RACGP's Standards for General Practice Q1.3.1 Managing clinic risks, C3.2 Accountability and Responsibility, Q1.1 Quality Improvement;
- accredited practices automatically meet the training standard 1.3;
- practices the meet the RACGP's Standards for general practice training or ACRRM's Standards for Supervisors and Training Posts should automatically qualify for training medical students, pre-vocational doctors and supervising IMGs or doctors under a supervision order as they would have all the appropriate systems, policies and procedures in place.

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.)

The AMA is unable to quantify these, particularly given the diversity of our GP membership. Training practices will be best placed to provide input on this.

19 August 2021

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